

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	1	9					
												REG. NO.											
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			William R. W. Aiken												MAY 27, 1981			4:35 P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH									6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			MONTH			DAY			YEAR			61			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH					
Exeter Penna.			USA			9			7			1919			Harford			Harford MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Havre de Grace			Harford Memorial Hospital												Councilor			Investment					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
Maryland			Harford			Bel Air			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			716 Country Village Drive											
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			LAST								
Harold			R.			Aiken						Alberta			Warner								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS														
Yes			WW-II			167-18-5870			Susan A. Vezzetti			Maryland 21085											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			1629			Adenoscarci... of the lung i metastasis																	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (b) massive cerebrovascular accident																	
						DUE TO, OR AS A CONSEQUENCE OF (c) arterio... arterio... disease																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE										
22a. I certify that (i) (that hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (i) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (do not) view the body after death.																							
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS																	
H. V. AYAKAWA M.D. 319 S. Union Ave. Havre de Grace MD.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE								
Cremation			28 May 1981			Cratin & Ferris			West Chester			Chester			Pa.								
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Tarring Funeral Home, P.A., Aberdeen, Md. 21001									MAY 1 1981			HARRY MULRONEY											

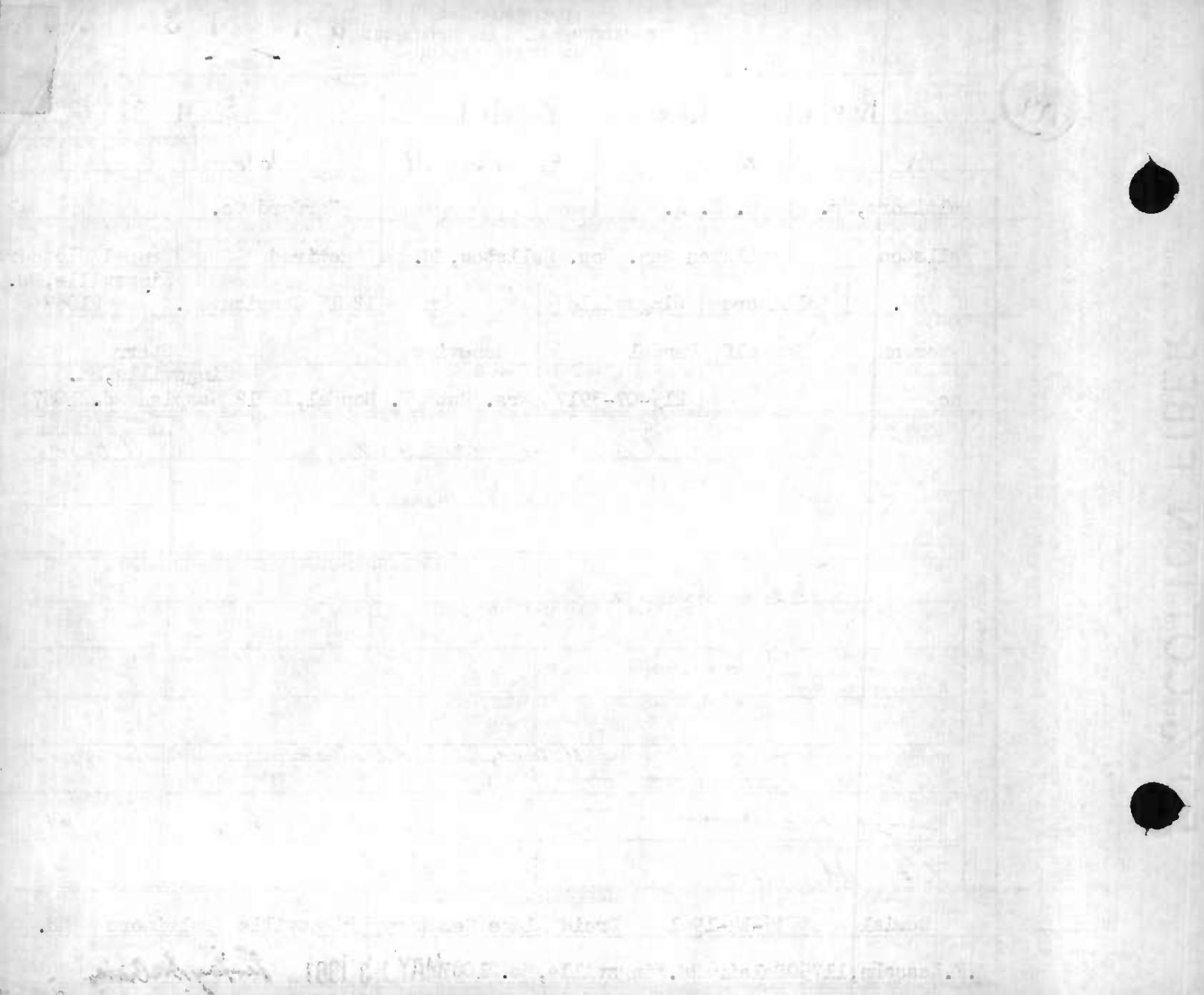
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medicolexamined at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 3 4 2 0				
1 - STATE REGISTRAR										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
ROBERT			LEE	Bandel		5 11 81					12 23	M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
M		W		5 26 14			66 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Baltimore, Md.		U. S. A.					Harford Co.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Fallston		Fallston Gen. Hos. Fallston, Md.		Retired			Bandel Cleaners							
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Kingsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 12012 Caspian Rd.			Kingville, Md. 21087	
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST							
Norman		Randolf		Genevieve			Starr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no		215-07-3917		Mrs. Ruth V. Bandel, 12012 Caspian Rd. 21087			Kingsville, Md.			There				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										4275				
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c). (b)										Cardiac arrest				
DUE TO, OR AS A CONSEQUENCE OF (c)										cardiac arrest				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ? None														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from 11 May 1981 to 10 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.														
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										11 May 81		
T.E. Harrison		PGM												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery			23d. LOCATION CITY OR TOWN Pikesville			COUNTY		STATE Md.		
Burial		5-14-1981												
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087				MAY 13 1981										

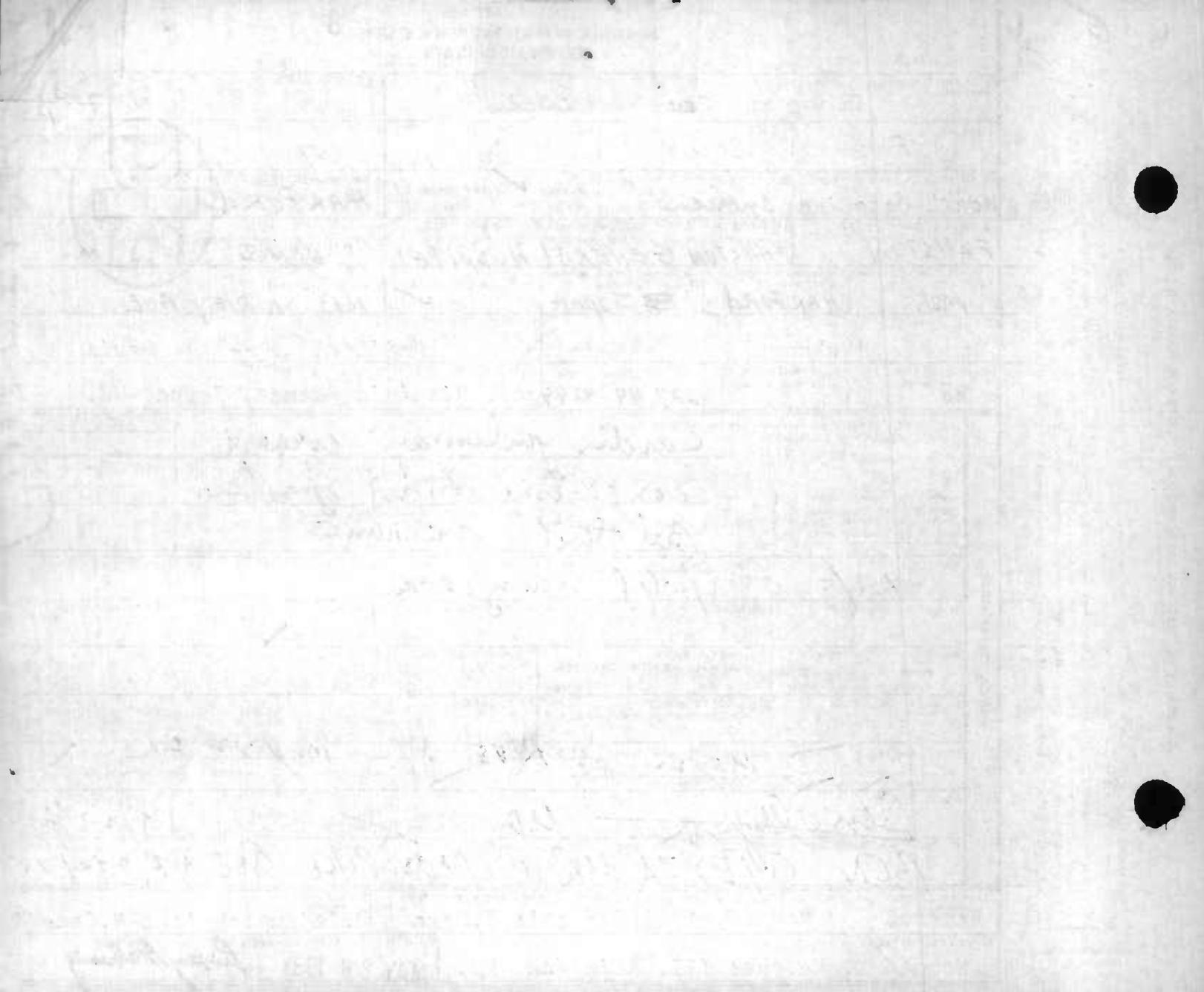


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 2 1				
												REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			5 22 81		7:53 PM		
Zenna Fay						Bare										
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		# UNDER 24 HRS		
F			Cau			MONTH 3 DAY 24 YEAR 14			67			MONTHS		DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
North Carolina			america			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD			MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
FALLSTON			FALLSTON GENERAL HOSPITAL			HOUSEKEEPER										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Md.			HARFORD			JOPPA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1613 SHIRLEY AVE				
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME				
(Unknown)												Matilda			Davis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
NO			227-44-9244			Mrs. Virginia Farmer, Joppa, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4860 Cardiac pulmonary arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (b) non cardiac heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral pneumonia																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) left occipital meningioma																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from May 22, 1981, to May 22, 1981, that (I) (we) last saw the deceased alive on May 22, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN			22e. MEDICAL DIRECTOR			STAFF PHYSICIAN		22f. DATE SIGNED		
BEN O'LEARY MD.														5/23/81		
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN	
BEN O'LEARY MD.			1131 BALD. PINE, BEL AIR, MD 21005			Removal			May 22, 1981			Badger's F. Home			W. JEFFERSON-ASHE-N. CARROLL	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Howard K. McComas III, Abingdon, Md.						MAY 26 1981						LARRY MCKEE				



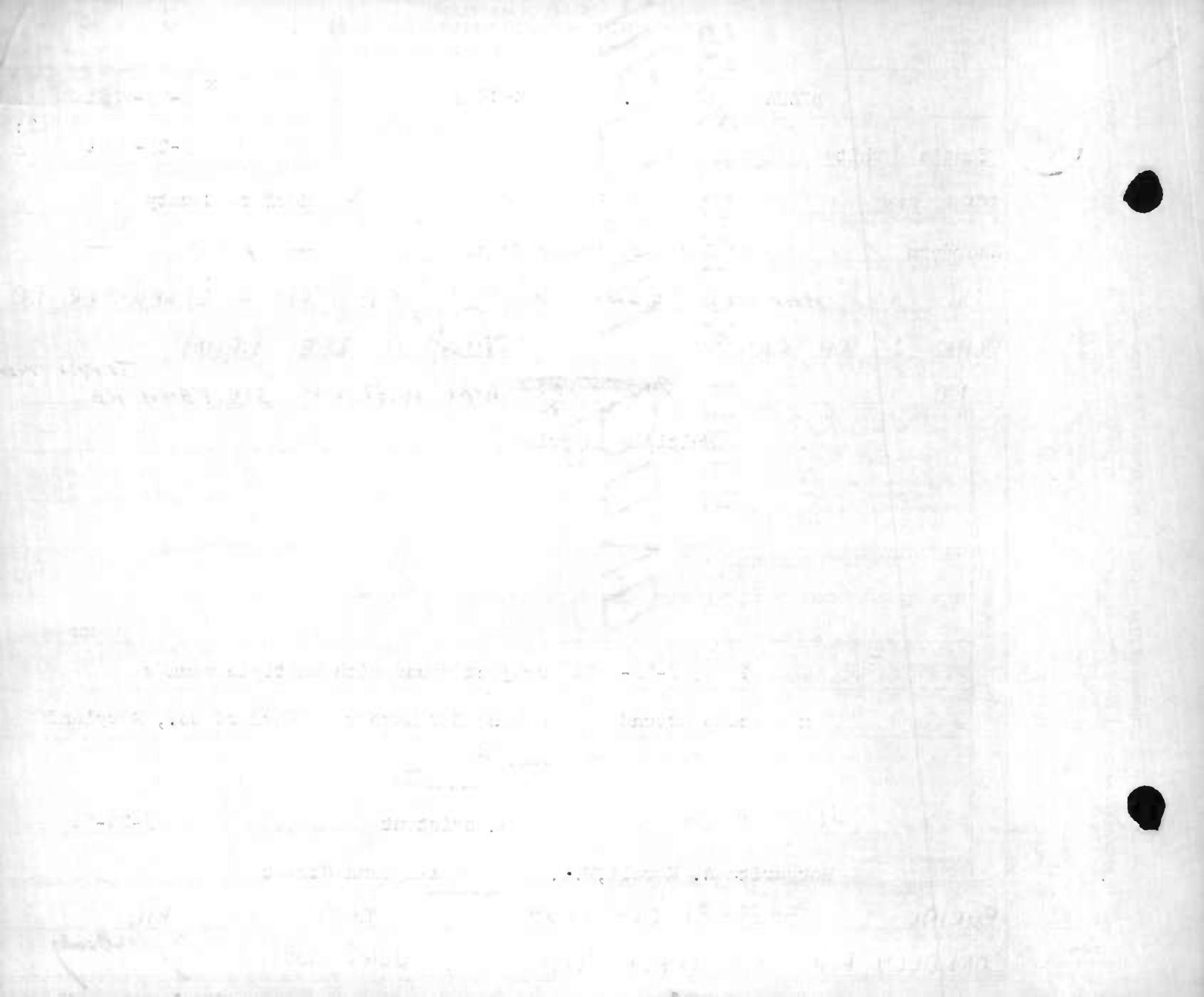
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS 281 W. PRESTON ST. BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												1 3 4 2 2			
1. DECEASED NAME (TYPE OR PRINT)											REG. NO.				
DIANA			L.			BECKER			2a. DATE MONTH DAY YEAR			2b. HOUR MONTH DAY YEAR			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE MONTH DAY YEAR		2d. DATE MONTH DAY YEAR	
female		white		5-20-60		21		MONTHS DAYS		HOURS MIN.		5-25-81		12:00 PM	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. PRONOUNCED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		UNITED STATES						Harford County							
10. ID CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Aberdeen		Long Bar Harbor-Camp Ground		—		—									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		13f. ADDRESS					
MD		HARFORD		EDGEMOOR		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1871 APT A		EDGEMOOR DR.					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
ALAN J. WATSON, SR.						VIRGINIA LEE DEAM									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		16d. ADDRESS		16e. ADDRESS		16f. ADDRESS					
NO		213-775850		WM. WATSON		510 PHILA. RD.		JOPPA MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
9660 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. DATE OF AUTOPSY?											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. DATE OF AUTOPSY?											
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5-25-81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
				subject found with multiple wounds											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) camp ground		21f. LOCATION STREET Long Bar Harbor		CITY OR TOWN Harford Co., Maryland		COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		MARGARITA A. KORELL, M.D.		TITLE (SPECIFY) M.D. ASSISTANT		MEDICAL EXAMINER		DATE SIGNED		5-26-81					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN BALTO.		23e. COUNTY MD.							
BURIAL		5-28-81		OAK LAWN											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
CONNELLY F.H.		300 MACE AVE.		JUN 5 1981		F. H. CONNELLY									

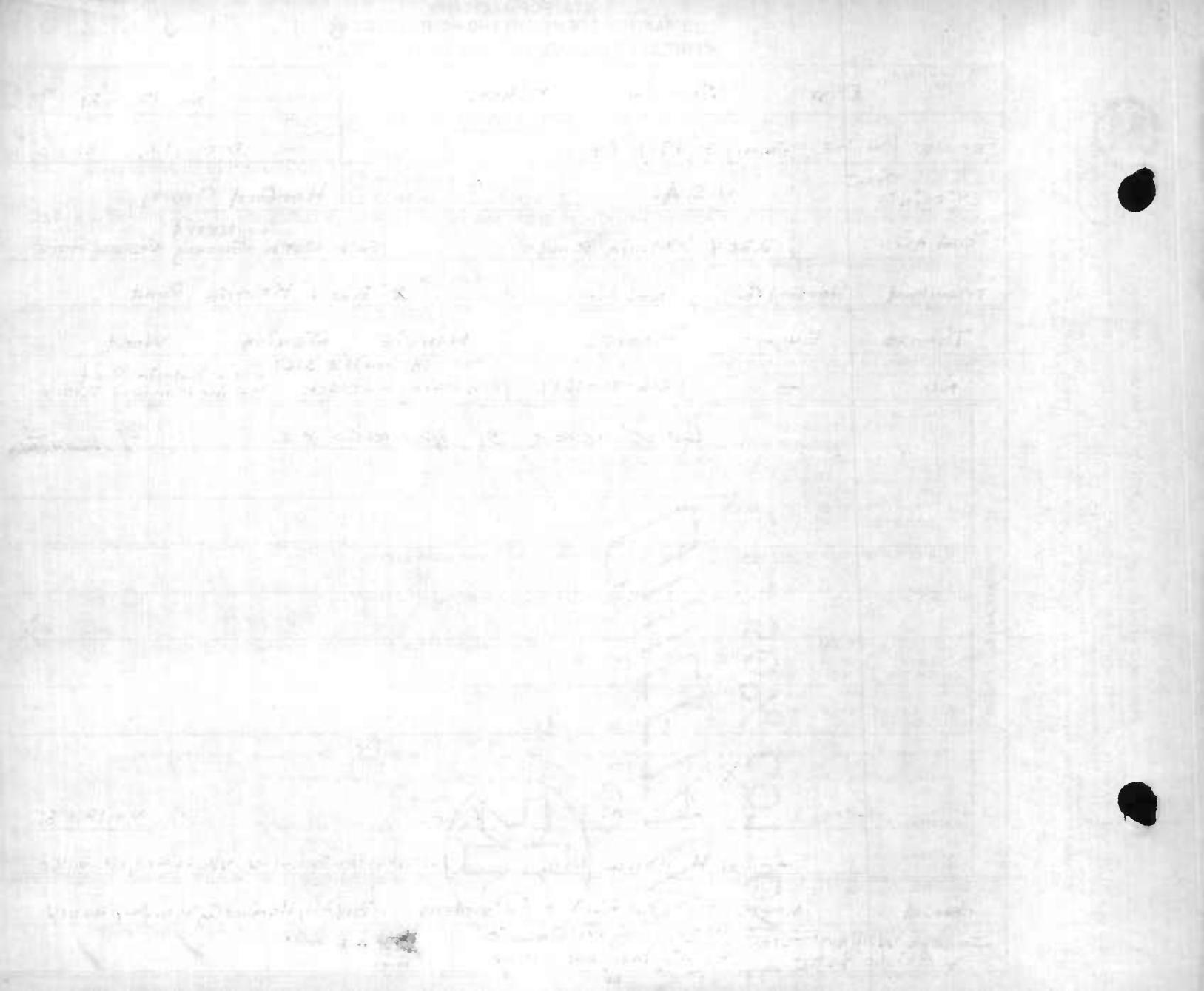


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 3 4 2 3					
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)									2a. DATE KNOWN OF DEATH ESTIMATED	2b. HOUR 4:35 P.M.				
			FIRST			MIDDLE			LAST			<input checked="" type="checkbox"/> <input type="checkbox"/>	MONTH	DAY	YEAR		
			Ora			Virginia			Black				May 12, 1981				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR 4:35 P.M.	
FEMALE		WHITE		January 31, 1917			64 yrs.							May 12, 1981			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Grant Virginia		U.S.A.					Harford County										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Bel Air		2204 Kalmia Road			Meat			SALES CLERK - GROCERY			General Store						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Maryland		Harford Co.		Bel Air						2204 Kalmia Road							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST Thomas		MIDDLE Edgar			LAST Rhodes			FIRST NANNIE			MIDDLE JENIVA			LAST Wood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT (Husband) 838-3269 ADDRESS Mr. Harry L. Black 2204 Kalmia Road Bel Air, Maryland 21014												
No		216-10-1619															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of pancreas</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months					
1579 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																	
18b. DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Samuel H. Henck</i>		TITLE (SPECIFY) M.D. <i>Deputy</i>										MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <i>721 Wheeler School Rd, Whiteford, Md. 21160</i>										DATE SIGNED <i>May 12, 1981</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE					
Burial		May 15, 1981		Bel Air Memorial Gardens			Bel Air, Harford Co., Maryland 21014										
24. FUNERAL DIRECTOR <i>Seamus William Foster</i>		ADDRESS <i>W. Broadway & Williams St Bel Air, Maryland 21014</i>		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
BP																	
DHMH-17 (VR A15 ME (5))																	
15M 7/77																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												8	1	1	3	4	2	4			
1. DECEASED NAME (TYPE OR PRINT)				FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
AVA M.				BOLT									5-20-81			11:30P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
F		W		MONTH 7			DAY 31			YEAR 88			MONTHS 92		DAYS YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
VIRGINIA		U.S.								HARFORD CO.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Havre de Grace				4003 York Drive								HOUSEWIFE				Home					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
MD.				HARFORD		Havre de Grace			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4003 York Drive									
14. FATHER'S NAME				FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME								
RILEY										SHULER			ELIZABETH				PARKS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				16c. INFORMANT				16d. ADDRESS				16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO				219-58-6418				Betty Jo DeBonis, 4003 York Drive, 21078													
18. CAUSE OF DEATH Enter only one cause per line for item 1b and 1c. PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)												19. DUE TO, OR AS A CONSEQUENCE OF (b)									
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)												ARTERIOSCLEROSIS -									
19. DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																					
22b. SIGNATURE Dante Monakil												22c. DEGREE									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL												22e. ADDRESS 622 S. Union Ave, Harford Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE Burial 30 May 1981				23c. NAME OF CEMETERY OR CREMATORIAL Gardens				23d. LOCATION CITY OR TOWN Aberdeen, R.D., Harford Md.				23e. COUNTY		23f. STATE			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001												25a. DATE REC'D. BY REGISTRAR 1981				25b. REGISTRAR'S SIGNATURE Dante Monakil					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for us as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8113425						
											REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Hannah Tunis Brookes												5/9/81				440 P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.					
F		W		MONTH 10 DAY 31 YEAR 88			92			MONTHS			DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Maryland		USA					Harford											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Fallston		Fallston General Hospital		Housewife			--											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Maryland		Harford		Bel Air						1901 Emmorton Rd.								
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
William		T.		Munnikhuyzen			Annie			--			Farnandis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
no		219-38-5038		Thomas R. Brooks, Jr., Bel Air, Md.			Cardio pulmonary Arrest			5 minutes								
5698		DUE TO, OR AS A CONSEQUENCE OF (b) Peritonitis																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) Perforated Sigmoid Colon																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
5/7/81				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/9/81 to 5/9/81, that (I) (we) lost the deceased alive on 5/9/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE				DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Willard P Amos										5/9/81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ESTATE			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE
Willard P Amos		2404 Pleasantville Rd., Fallston, Md. 21047		Burial			May 12, 1981			St. Mary's Episcopal Cemetery			Abingdon			Harford		Md.
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Howard K. McComas III, Abingdon, Md.				MAY 12 1981														



OPTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

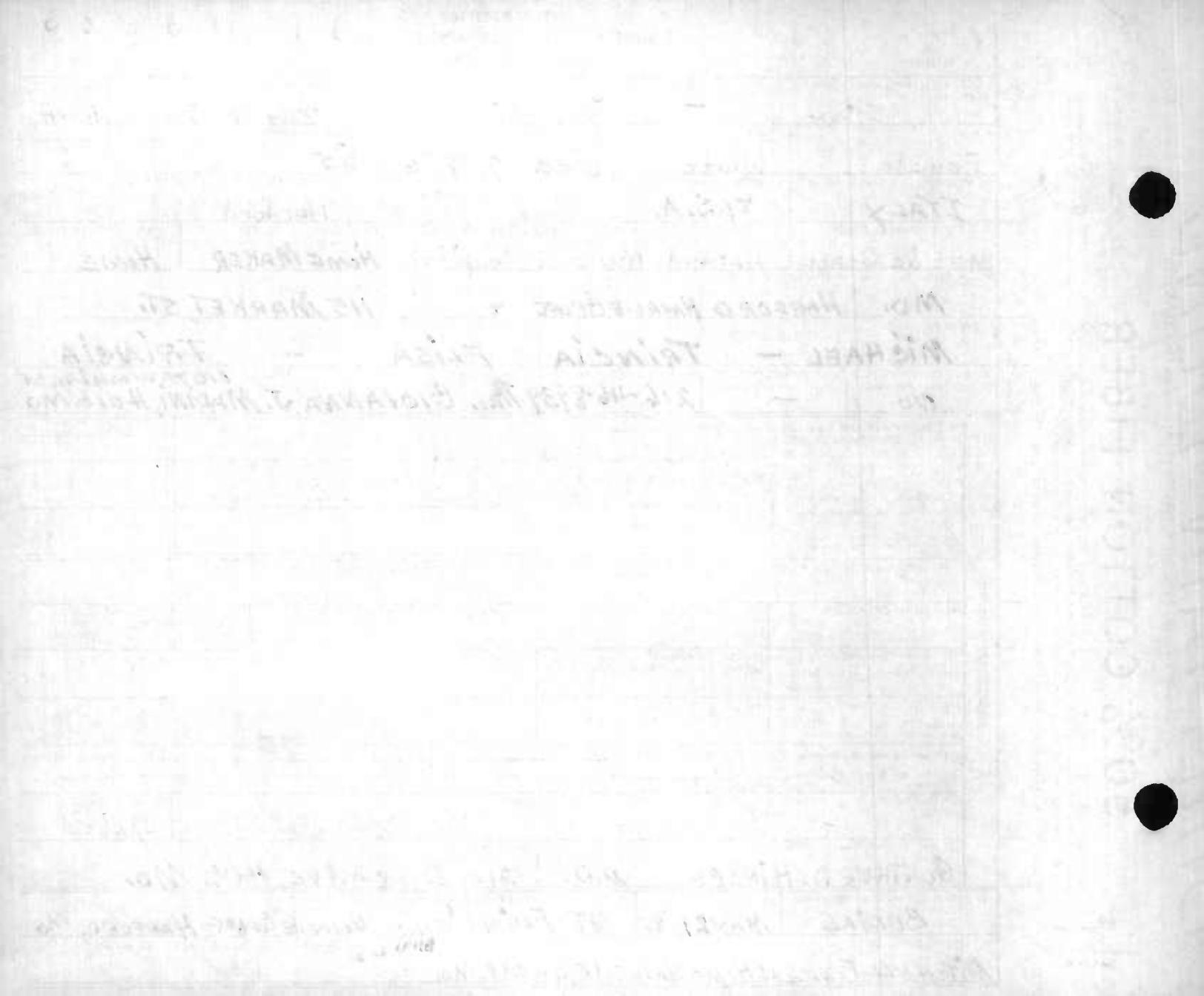
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or on call.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 3 4 2 6				
										REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		MAY 18, 1981		11:10 A M			
Elisa			-		-		Bucchi							
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female			White			FEB 7 1896			85			YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
ITALY			U.S.A.						Harford			Harford		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY					
Havre de Grace			Harford Memorial Hospital			Home MAKER			Home					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
MD.			HARFORD			HARFORD			YES			115 MARKET ST.		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
MICHAEL -			TRINICIA ELISA -			216-46-8939			Mrs. Giovanna J. Marini, H-deb, Mo			10 W. WASHING ST		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19b.									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/8 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										60 to 5:15 19 81				
22b. SIGNATURE										DEGREE	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	5/8/81			
GUNTHER D. HIRSCH M.D.										1215 Lemon Ave., Hale, Mo.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN					
BURIAL			MAY 21, 81			MT ERIN CEM.			HARFORD, MD					
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR				
MICHAEL FUNERAL HOME, HARFORD, MD										25b. REGISTRAR'S SIGNATURE				
BP														
DHMH-16 30M 2/80 (VRA 15.4)														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												B 1 1 3 4 2 1		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR			
Paul Steele Buffington						5 22 81			8:28 PM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
M			Cau			MONTH 9 DAY 21 YEAR 22			58			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Penns.			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD			YRS.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
FALLSTON			FALLSTON GENERAL HOSPITAL			Programmer			US-govt.					
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2400 Sycamore Lane		
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME								
Andrew --			Buffington			Tess --								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes			WWII 179-12-5865			Mrs. Anne Buffington, Edgewood, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a) and (b)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4149 <i>Ventricular fibrillation</i>												Sudden		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery Disease</i>												20 years.		
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHERE AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/22 1981, to 5/22 1981, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Edward C. Loo, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/23/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. Loo, M.D.			22e. ADDRESS 1400 E. 36th Street, Baltimore, Md. 21218											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE May 23, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Security Process			23d. LOCATION Baltimore			COUNTY Md. STATE		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAY 26 1981			25b. REGISTRAR'S SIGNATURE <i>Howard McComas</i>					

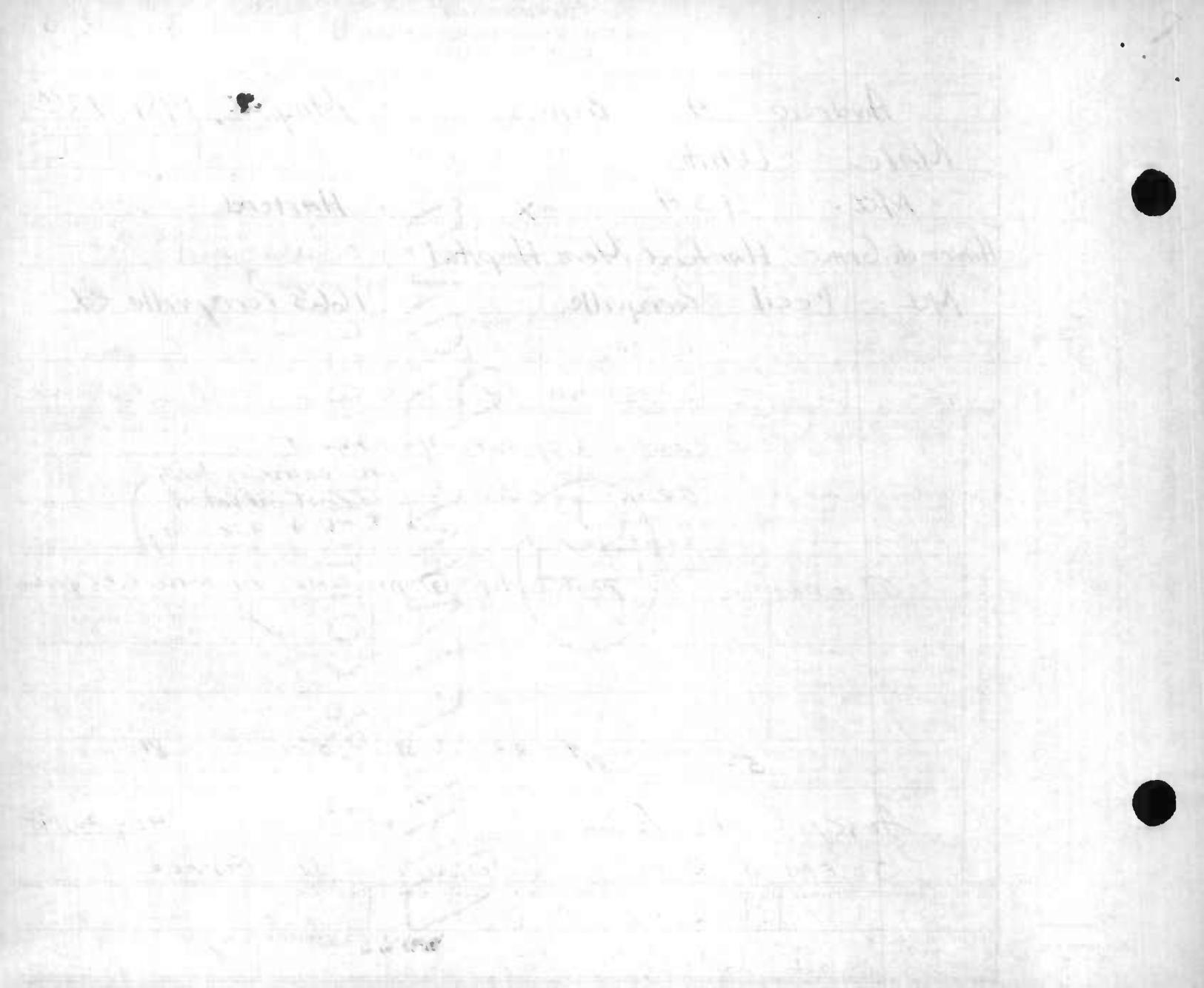
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 2 8			
												REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Andrew A. Bures									May 20, 1981			12 M			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS, LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male			White			11 30 1897			83						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.						
Md.			U.S.A			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
10. CITY OR TOWN OF DEATH Harve de Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled - None			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Cecil			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1663 Perryville Rd.						
14. FATHER'S NAME Joseph			15. MOTHER'S MAIDEN NAME Mary									LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW I 213-52-3614			17. INFORMANT Frederick Bures 7941 Oakdale Ave.			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (b) <u>Renal failure</u> (the cause of death is not related) (c) <u>septicemia</u> (to V.A. disability)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Anemia</u> <u>senility</u> <u>probable diverticulitis colon</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-22</u> , 19 <u>81</u> , to <u>5-</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>5-</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Joseph J. Kim			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED May 20, 1981						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH J. KIM			22e. ADDRESS Harve de Grace												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 22, 1981			23c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer			23d. LOCATION CITY OR TOWN Balto.			COUNTY	STATE Md.		
24. FUNERAL DIRECTOR John Walsh			ADDRESS 1211 Chesaco Ave.			25a. DATE REC'D. BY REGISTRAR 1981-05-20			25b. REGISTRAR'S SIGNATURE						



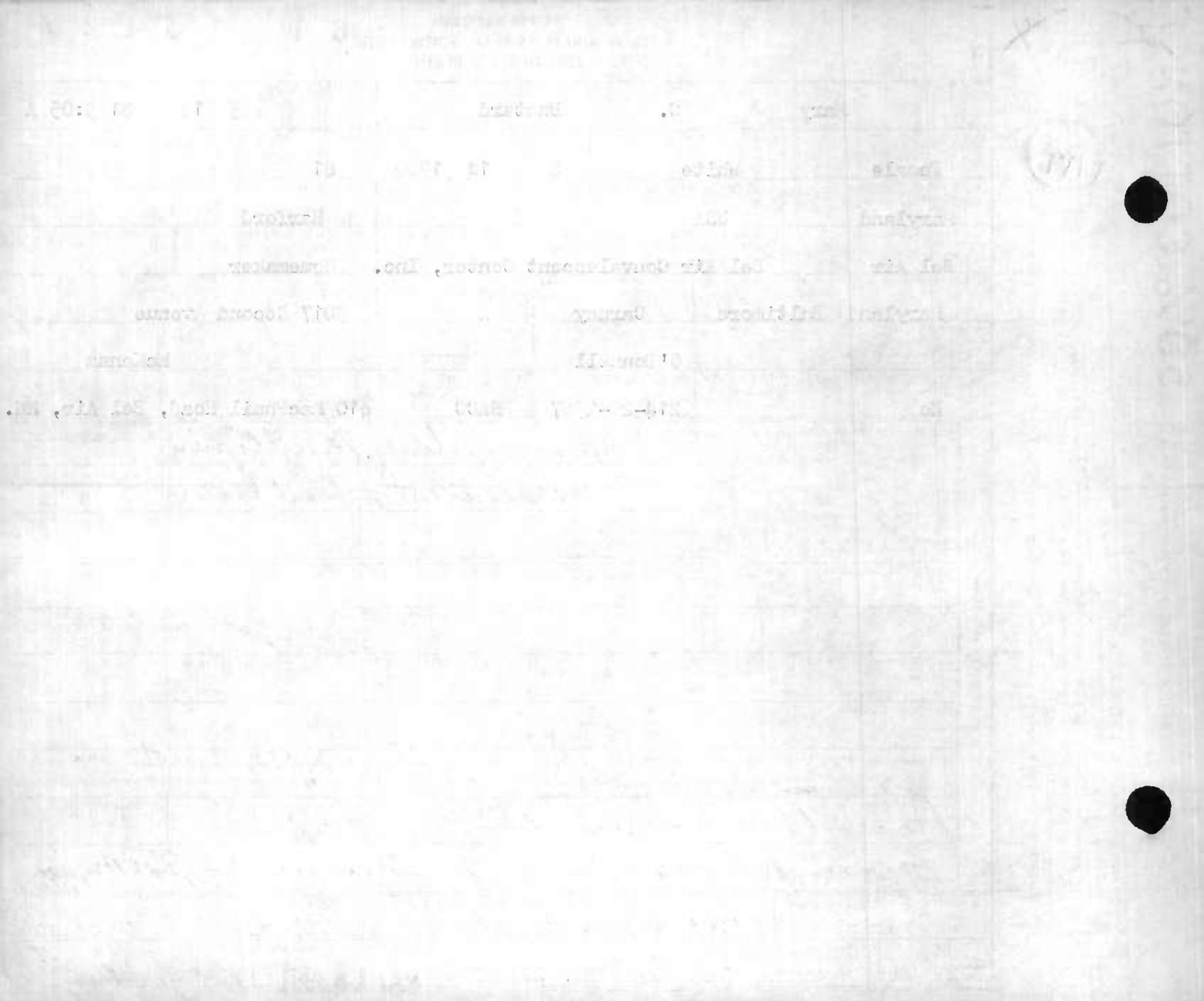
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-formal permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 3 4 2 9			
1 - FOR STATE REGISTRAR										REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Mary		C.		Bustard				5 14		81		3:05 A.M.	
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 2 DAY 14 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS YRS.		8. IF UNDER 24 HRS DAYS		9. IF UNDER 24 HRS HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		11. CITIZEN OF WHAT COUNTRY? USA		12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		13. BALTIMORE CITY OR COUNTY OF DEATH Harford		14. USUAL RESIDENCE (IF NOT IN HOSPITAL OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland Baltimore		15. CITY OR TOWN Carney		16. USUAL OCCUPATION Homemaker	
17. CITY OR TOWN OF DEATH Bel Air		18. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS Bel Air Convalescent Center, Inc.		19. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. STREET ADDRESS 3017 Second Avenue		21. STATE Maryland		22. KIND OF BUSINESS OR INDUSTRY McKenna			
23. FATHER'S NAME John		24. MOTHER'S MAIDEN NAME O'Donnell		25. ADDRESS 410 MacPhail Road, Bel Air, Md.									
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		27. SOCIAL SECURITY NO. 214-20-2987		28. INFORMANT BACC		29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Heart failure, Anemolytic Atherosclerotic heart disease		30. DATE OF OPERATION		31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		36. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
37. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		38. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		39. LOCATION STREET		40. CITY OR TOWN		41. COUNTY		42. STATE			
43. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>12/16</u> 19 <u>78</u> to <u>5/14</u> 19 <u>81</u> , that <input type="checkbox"/> (we) lost the deceased alive on <u>5/14</u> 19 <u>81</u> and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.													
44. SIGNATURE Andrew Nowakowski		45. DEGREE MD.		46. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		47. DATE SIGNED 1981							
48. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Nowakowski		49. ADDRESS 715 Shamrock Rd., Bel Air, Md. 21014											
50. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		51. DATE 5/16/1981		52. NAME OF CEMETERY OR CREMATORIAL New Cathedral		53. LOCATION CITY OR TOWN Baltimore		54. COUNTY		55. STATE Maryland			
56. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		57. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222		58. DATE REC'D. BY REGISTRAR MAY 18 1981		59. REGISTRAR'S SIGNATURE Victor McElroy							



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 3 4 3 0

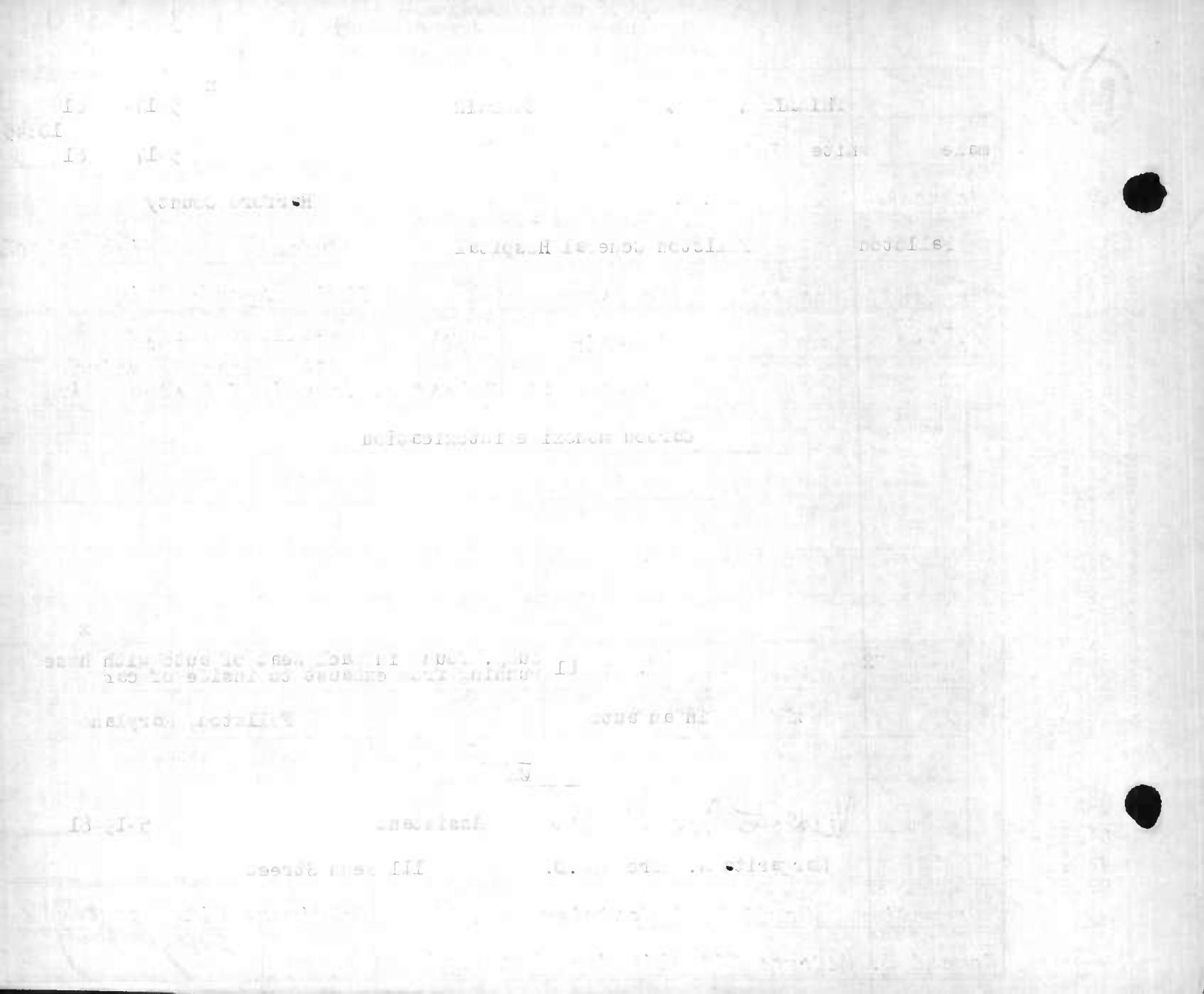
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-17- 19 81				2b. HOUR <input type="checkbox"/> 10:45 M	
PHILLIP		EDWIN		CAMPAIN								
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	9. BALTIMORE CITY OR COUNTY OF DEATH	10. HOUR <input type="checkbox"/> 10:45 PM		
male	white	July 25 1964	16	MONTHS	DAYS	HOURS	5-17- 19 81		Harford County			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Nebraska		U.S.A.					Harford County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Fallston		Fallston General Hospital			Student		High School					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS				
Maryland		Harford		Fallston				2502 Burgandy Drive				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Robert Dean				Campain	FIRST	Ruth	Elizabeth Nance					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		2502 Burgandy Drive						
NO		NONE		200-50-2444		Robert D. Campain Fallston, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I DEATH WAS CAUSED BY: Carbon monoxide intoxication APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
9520 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8 PART I OR PART II)		SUBJ. found in back seat of auto with hose running from exhaust to inside of car						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in an auto		21f. LOCATION STREET		CITY OR TOWN Fallston, COUNTY Maryland STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Margarita A. Korell</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												
DATE SIGNED 5-19-81												
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.			ADDRESS		111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		Baltimore City Maryland				
Cremation		May 21, 1981		Westview Mem. Pk.								
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Howard K. McComas		III Abingdon, Maryland		MAY 21 1981		<u>Howard K. McComas</u>						
DHMH-17 (VRA15 ME (5)) 15M 2/80												



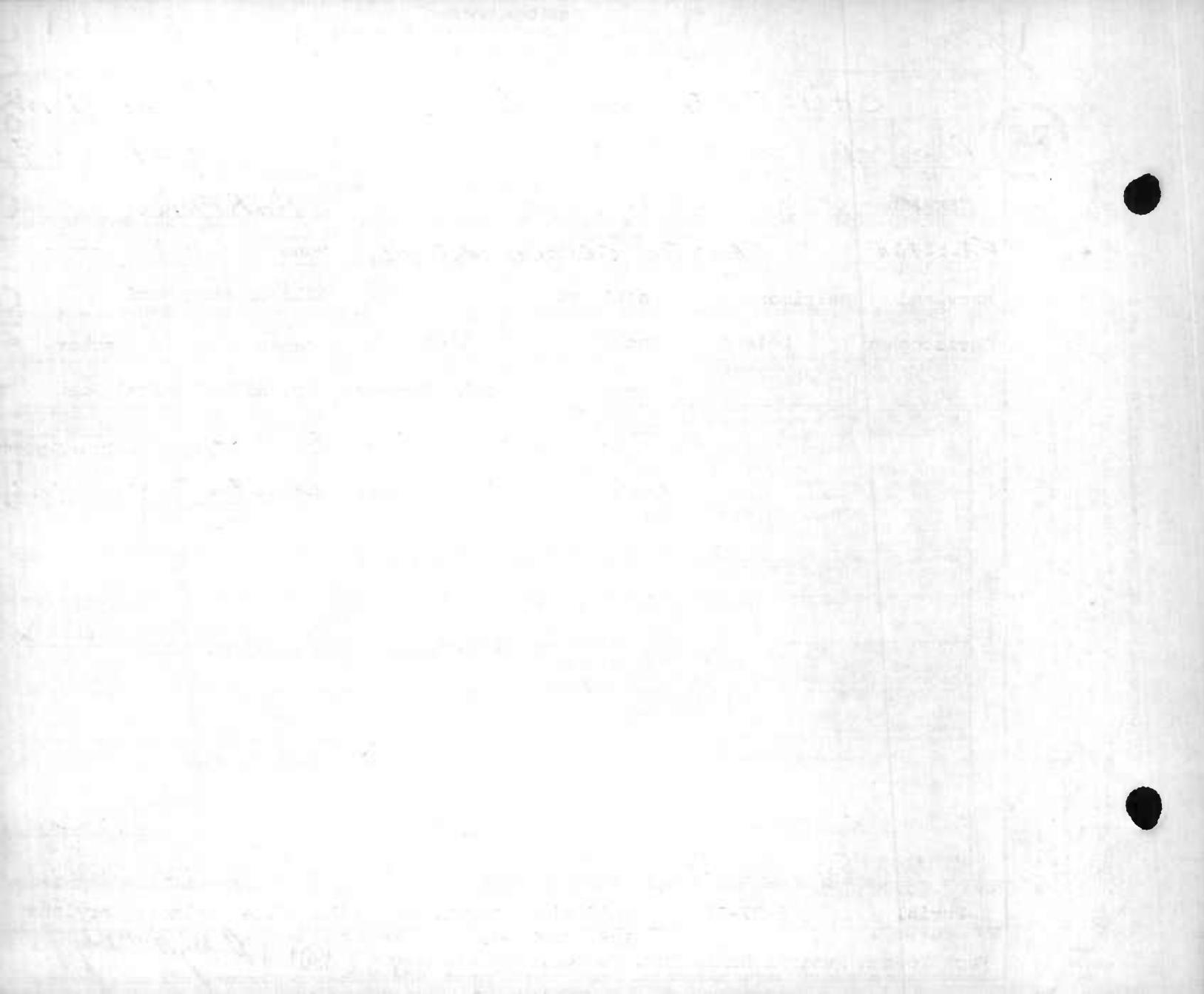
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13431

1- STATE REGISTRAR		REG. NO.												
I. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH MATED	2b. MONTH MONTH	2b. DAY DAY	2b. YEAR YEAR	2b. HOUR HOUR
CHRISTOPHER		Charles			COCKEY					<input checked="" type="checkbox"/> 5 24 1981	10 24 M			
SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH July	DAY 20, 1979	YEAR 1979	6. AGE (IN YEARS LAST BIRTHDAY) 1 YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD	MONTH 5 24	DAY 10 24	YEAR 1981	2d. HOUR M
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>		MD.				
10. CITY OR TOWN OF DEATH <i>FALLSTON</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FALLSTON GENERAL HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>None</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>						
13a. STATE <i>Maryland</i>		14. FATHER'S NAME FIRST <i>Christopher</i>		MIDDLE <i>Delano</i>		LAST <i>Cockey</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Alice</i>		MIDDLE <i>Susan</i>		LAST <i>Barker</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>John Merryman, Jr.</i>		ADDRESS <i>5500 Chemical Road</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8149 IMMEDIATE CAUSE (a) <i>multiple severe internal injuries</i> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF (b) <i>auto - pedestrian accident</i> immediate DUE TO, OR AS A CONSEQUENCE OF (c) immediate														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Samuel H. Henck</i>		M.D.		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER <i>728 Wheeler School Rd.</i>		DATE SIGNED <i>5/24/81</i>						
EXAMINER'S NAME (TYPE OR PRINT) <i>Samuel H. Henck, M.D.</i>		ADDRESS <i>728 Wheeler School Rd. Whiteford, Md. 21160</i>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-27-81</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Druid Ridge Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Pikesville, Balto., Maryland</i>		23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>Ruck Towson Funeral Home, Inc.</i>		ADDRESS <i>Towson, Md. 21204</i>		1050 York Rd.		25a. DATE REC'D. BY REGISTRAR <i>MAY 27 1981</i>		25b. REGISTRAR'S NAME <i>Henry Kelley</i>						
BP														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	3	2					
												REG. NO.											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Mary Naomi Cole												May 19, 1981						4 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS								
Female			Black			Month Day Year			77			MONTHS DAYS			HOURS MIN.								
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH								
Pa.			USA						Harford			Harford			Harford								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HIGH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Harford Grace			Harford Mem. Hospital			Domestic			But Family														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS											
Md.			Harford			Harford Grace						575 Girard St.											
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS											
Valentine						HANNA			216-12-7035			Mary Gray			Corona, N.Y.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Reproductive Failure																	
4960						DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(b) Chronic Obstructive Pulmonary Disease																	
						(c) Chronic Coagulopathy																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
			P.M. 19																				
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from 5-16, 1981, to 5-19, 1981, that (I) (we) last saw the deceased alive on 5-19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			22c. DATE SIGNED								
SANG W. KIM															5/19/81								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTRY											
Burial			May 23, 1981			Berkley Cemetery			Baltimore, Maryland			Md.											
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
Otelie J. Bullock			2700 Maryland			MAY 20 1981			Helen Kennedy														

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5, RETAIN TO PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

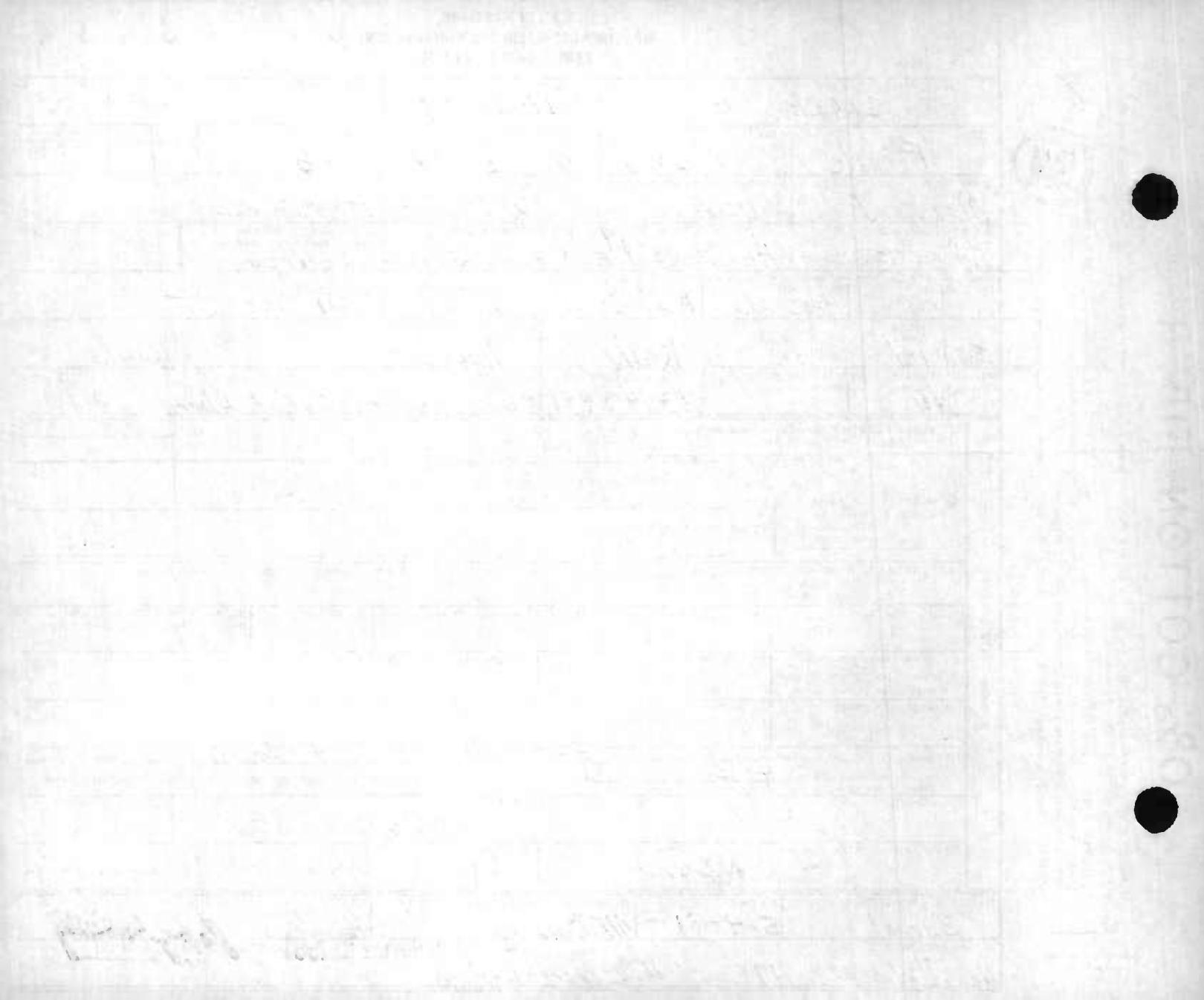
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 13433		
1. DECEASED NAME (TYPE OR PRINT)			FIRST Todd	MIDDLE Dewayne	LAST Crigger	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>			MONTH 5	DAY 7	YEAR 1981	2b. HOUR M		
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH July DAY 31 YEAR 1961	6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS.	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. HOURS 0	10. MIN. 0	2c. DATE PRONOUNCED DEAD 5 7 19 81			2d. HOUR 9:45PM			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County							
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Sevel Plastic						
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 823 Carlton Rd.						
14. FATHER'S NAME George		15. MIDDLE W.		16. LAST Crigger		17. MOTHER'S MAIDEN NAME Donna		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 226-06-5212		17. INFORMANT Donna L. Anderson, 561 Fountain St.		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8162 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		19c. DUE TO, OR AS A CONSEQUENCE OF		(b) DUE TO, OR AS A CONSEQUENCE OF		(c) DUE TO, OR AS A CONSEQUENCE OF		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 8:30 AM 5/7 1981			21b. TIME OF INJURY HOUR MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of motorcycle, lost control, overturned
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK XX		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET Stafford Rd, Darlington, Harford Co.		CITY OR TOWN STATE MD								
22a. I certify that I took charge of the remains described above, held an death resulted from: Nature of cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TITLE (SPECIFY) Assistant M.D.		22c. MEDICAL EXAMINER		22d. DATE SIGNED 5/8/81								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 10, 1981		23c. NAME OF CEMETERY OR CREMATORIUM Angel Hill Cemetery		23d. LOCATION CITY OR TOWN Havre de Grace, Harford, Md.								
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		25a. DATE REC'D. BY REGISTRAR MAY 13 1981		25b. REGISTRAR'S SIGNATURE Lee A. Patterson & Son										
BP		DMMH-17 (VR A15 ME (5)) 15M 2/00												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removals.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 3 4					
												REG. NO.					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			4-30-81			133 P M		
CLARA E									DABNEY								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
Female			Negro			MONTH 7 DAY 2 YEAR 14			66			MONTHS			DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			HARFORD		
Maryland			USA														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
HAKE de Grace			HARFORD MEMORIAL HOSPITAL			Retired											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md			HARFORD			Aberdeen			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			411 OAK ST					
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME					
Samuel			B.			Kelly			Mary			Banks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(YES, NO OR UNKNOWN)			103-14-8451						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Edna Sonica 429 OAK St. Aberdeen Md.					
NO									1629			acute cardiac - my arrest					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									DUE TO, OR AS A CONSEQUENCE OF (b)			myocarditis CA - generalized					
									DUE TO, OR AS A CONSEQUENCE OF (c)			CA of lung					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
												YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4-30-81, 1981, to 4-30-81, 1981, that (I) (we) last saw the deceased alive on 4-30-81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			5-4-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			695 S. Union St., Harford								
Burial			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			25a. DATE REC'D. BY MEDICAL DIRECTOR			25b. REGISTRATION SIGNATURE		
Burial			5-4-81			Mt. Calvary			Bridgeton			1981					
24. FUNERAL DIRECTOR NAME			ADDRESS														
Arnold W. Beard 117 Cecil Ave North East, MD																	
DHMH-16 30M 2/80 (VRA 15, 4)																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	3	5	
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Elizabeth									Deeds			5-27-81					3 rd P M		
3. SEX			4. RACE						5. DATE OF BIRTH			6. AGE [IN YEARS (LAST BIRTHDAY)]		IF UNDER 1 YEAR		IF UNDER 24 HRS			
F			Cauc						MONTH DAY YEAR			46		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
New York			U.S.A.									HARFORD		HARFORD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
FALLSTON			FALLSTON GENERAL HOSPITAL			Housewife			Own Home										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Md			Harford			Fallston			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1514 Ryan Road							
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			N/A				
FAED									GOKEY			HARALINETTE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			—			NONE			LLOYD (HUSBAND) DEEDS			Same As #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Respiratory Arrest							
1469																			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) Ovarian Cancer							
												DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/26 81 to 5/27 81, that (I) (we) last saw the deceased alive on 5/26 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
Willard P. Amoss						MD						5/27/81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				
Willard P. Amoss			2404 Pleasantville Rd, Fallston MD			BURIAL			5/30/81			FALLSTON METHODIST CH. & CEM			FALLSTON				
24. FUNERAL DIRECTOR NAME			ADDRESS			21018			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
E. Barnes			Benson, MD			JUN 2 1981						Patty Melody							
FLEMING FUNERAL SERVICE																			

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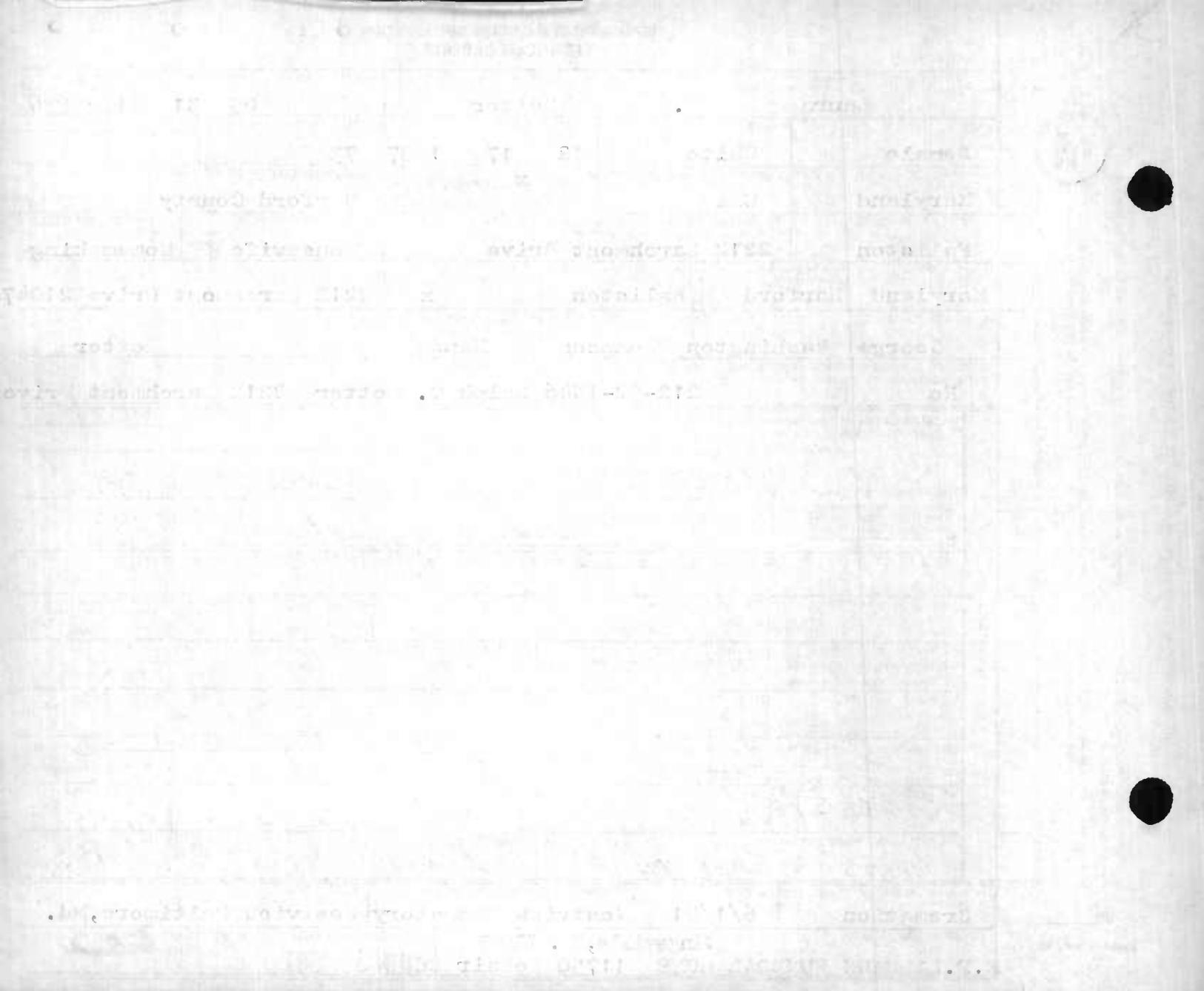
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 3 4 3 6 CERTIFICATE OF DEATH												REG. NO.				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH 05 31 81									2b. HOUR 5:00 P.M.				
1 DECEASED NAME (TYPE OR PRINT) Laura T. Dettor			MIDDLE			LAST			3. SEX Female			4 RACE White	5. DATE OF BIRTH MONTH 12 DAY 17 YEAR 1907	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.							
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2212 Larchmont Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaking							
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Fallston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2212 Larchmont Drive 21047				
14. FATHER'S NAME FIRST George			MIDDLE Washington			LAST Thompson			15. MOTHER'S MAIDEN NAME FIRST Maude			MIDDLE LAST Potter				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-52-1546			17. INFORMANT Ralph C. Dettor			ADDRESS 2212 Larchmont Drive			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic lung carcinoma to brain</u> 3/81 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous cell carcinoma of lung</u> 11/80																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 22. I certify that (I) this hospital attended the deceased from <u>November</u> , 19 <u>80</u> , to <u>May</u> , 19 <u>81</u> , that (I) we last saw the deceased alive on <u>Aug 15</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) we did not view the body after death.			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. SIGNATURE Mother Spender			22b. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/1/81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN J. SPENDER			22e. ADDRESS Good Samaritan Hospital, Belts. MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6/1/81			23c. NAME OF CEMETERY OR CREMATORIAL Westview Crematory			23d. LOCATION CITY OR TOWN Westview			COUNTY Baltimore	STATE Md.			
24. FUNERAL DIRECTOR NAME E. F. LASSAHL FUNERAL HOME			ADDRESS 11750 Belair Rd.			25a. DATE REC'D. BY REGISTRAR JUN 5 1981			25b. REGISTRAR'S SIGNATURE John J. Murphy							
BP _____																
DHMH-16 30M 2/80 (VRA 15, 4)																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 30 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	13	4	3	7			
												REG. NO.								
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									MONTH	DAY	YEAR	2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
William John Dubree												May 9, 1981					9:20 AM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
Male			white			MONTH NOV. DAY 27 YEAR 1906			74			MONTHS		DAYS		HOURS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.								
MD			U.S.A.						Harford											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)								
Havre de Grace			Harford Memorial Hospital									12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
MD			HARFORD			HAVRE DE GRACE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3810 WILKINSON ROAD.								
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME														
ARTHUR C. DUBREE						LILIE														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT														
YES			WW #2 217-22-0013			MABLE L. DUBREE														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4148 CARDIAC ARREST									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC CARDIOMYOPATHY																	
			DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWNSHIP			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/9/81 to 5/9/81, that (I) (we) last saw the deceased alive on 5/9/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE			DEGREE									ATTENDING PHYSICIAN			MEDICAL STAFF			22c. DATE SIGNED		
DANTE N. MONAKIL												<input checked="" type="checkbox"/>			<input type="checkbox"/>			5/9/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																	
DANTE N. MONAKIL			672 S. Union Ave Havre de Grace, MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWNSHIP			24. FUNERAL DIRECTOR NAME								
BURIAL			MAY 12 1981			ROCKS RUN			HARFORD			25a. DATE REC'D. BY REGISTRAR								
												25b. REGISTRAR'S SIGNATURE								
												HARFORD								

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 3 4 3 8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)	LAST		2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
JOHN FRANKLIN ELLIS JR	JOHN	FRANKLIN	15	7	19	81	11:00 AM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGES (IN YEARS) IN MONTHS	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS	9. HOURS	10. MIN.
M	B	8 30 57 1981	81	0	0	0	0
11a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	11b. CITIZEN OF WHAT COUNTRY?	11c. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
MD	USA	813 LOCUST ST.		HARFORD		HARFORD	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	14. FATHER'S NAME		
MD	HARFORD	HARFORD DE GRACE	YES <input checked="" type="checkbox"/>	813 LOCUST ST. DE GRACE	FIRST	MIDDLE	LAST
15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, ONE WAR OR DATE)			17. INFORMANT	ADDRESS
EVELYN			NO			FATHER	MURRAY
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GRAND MAL SEIZURES DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) EPILEPSY DUE TO, OR AS A CONSEQUENCE OF (c)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
23a. ACTUAL SIGNATURE Luis E. RENTZEL, M.D.							
23b. TITLE (SPECIFY) MEDICAL EXAMINER							
23c. EXAMINER'S NAME (TYPE OR PRINT) Luis E. RENTZEL, M.D.							
23d. ADDRESS 444 ALLIANCE ST HARFORD DE GRACE							
23e. BURIAL, CREMATION, REMOVAL (SPECIFY)	23f. DATE 5-12-81	23g. NAME OF CEMETERY OR CREMATORIAL ST. JAMES	23h. LOCATION CITY OR TOWN HARFORD DE GRACE	23i. COUNTY MD.	23j. STATE MD.		
24. FUNERAL DIRECTOR NAME GEORGE W. TITTLE BELAIR	ADDRESS 21014	25a. DATE REC'D. BY REGISTRAR MAY 15 1981	25b. REGISTRAR'S SIGNATURE Loyalty				

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

1884] H. C. LEWIS

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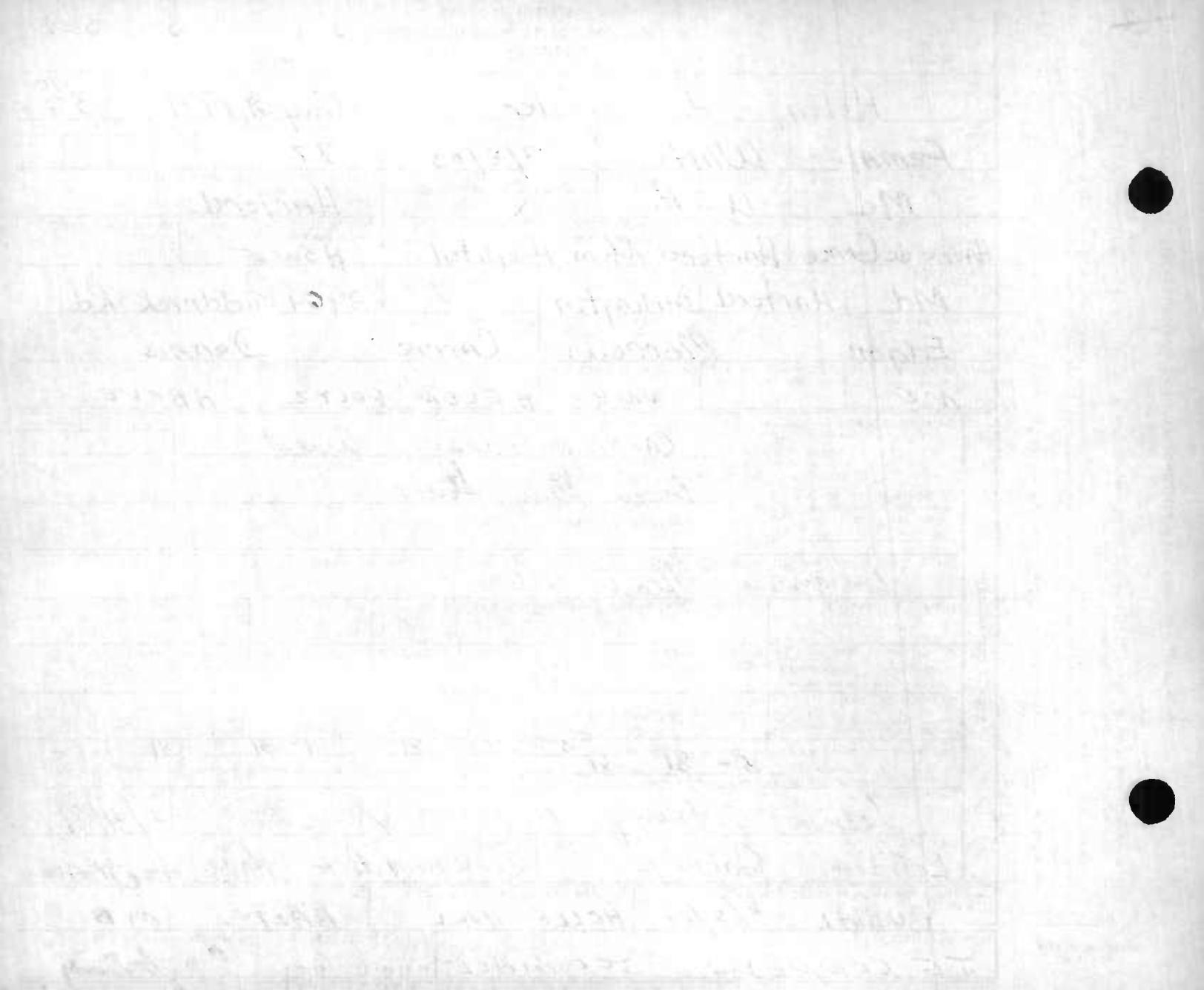
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	3	9					
												REG. NO.											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOURS		
			Helen A. Foster												May 31, 1981			12	15	1981	3 1/2 M		
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH			DAY			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female			White			7/8/83									77			MONTHS	DAYS	HOURS	MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			MARRIED			NEVER MARRIED			WIDOWED			DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md			U.S.A.						<input type="checkbox"/>			<input type="checkbox"/>			<input checked="" type="checkbox"/>			<input type="checkbox"/>		Harford			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN 10th FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Havre de Grace			Harford Mem. Hospital			H.S.W.																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
Md			Harford			Darlington			YES <input type="checkbox"/>			NO <input type="checkbox"/>			3909 Paddrick Rd								
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME											
Edgar						Morrison						Carrie											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS														
NO			UNK			H. ELLEN FOLTZ						ABOVE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360															Cardio pulmonary Arrest								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
DUE TO, OR AS A CONSEQUENCE OF (b) Brain stem stroke																							
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) congestive heart failure																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/>			NO <input type="checkbox"/>			YES <input type="checkbox"/>			NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from 5-13, 1981, to 5-31, 1981, that (I) (we) last saw the deceased alive on 5-31, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Leticia J. Galvez			DEGREE M.D.			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			22c. DATE SIGNED 5/31/81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leticia Galvez			22e. ADDRESS 80. Union Ave. Havre de Grace																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/3/81			23c. NAME OF CEMETERY OR CREMATORIAL HOLLY HILL			23d. LOCATION CITY OR TOWN BALTO. MD			COUNTY			STATE								
24. FUNERAL DIRECTOR NAME T. E. CONNELLY			ADDRESS 300 MACE						25a. DATE REC'D. BY REGISTRAR JUN 9 1981			25b. REGISTRAR'S SIGNATURE P. Kelly Schenck											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If death occurs at home or in a nursing home, or if the deceased is a resident of a nursing home, the medical examiner must be advised as soon as possible.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 13440

• REG. NO. 6

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR												
DOROTHY C			GECKLE			5	17	81	6:09 AM													
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS										
FEMALE		WHITE		MONTH	DAY	YEAR	59	YRS			MONTHS	DAYS	HOURS	MIN.								
7a. BIRTHPLACE (COUNTRY)		7b. STATE OR FOREIGN MD.		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY															
FALLSTON		FALLSTON GENERAL HOSPITAL		Homemaker																		
13a. STATE Md.												13b. COUNTY HARF		13c. CITY OR TOWN Belair			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1512 Southview Road		
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME Regina			MIDDLE		LAST										
Irwin		A.		Berends						E.												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
No				218-07-8868			Mr. Melvin Geckle			1512 Southview Road												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
IMMEDIATE CAUSE (a) HYPOXIC BRAIN DAMAGE 4140 DUE TO, OR AS A CONSEQUENCE OF CREDITIC ARREST												7 days										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.																						
DUE TO, OR AS A CONSEQUENCE OF (b) CREDITIC ARREST																						
(c) SEVERE ATHEROSCLEROTIC HEART DISEASE																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>May - 9 -</u> 19 <u>81</u> , to <u>May 17</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>May 17</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 5/9/81.										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
A. J. SUGATHAN M.D.		Faison Gen. Hospital, Faison Md.			M.D.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE											
Removal		5/17/81																				
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																	
Anatomy Board		Balto., Md.			AN 25 1981																	

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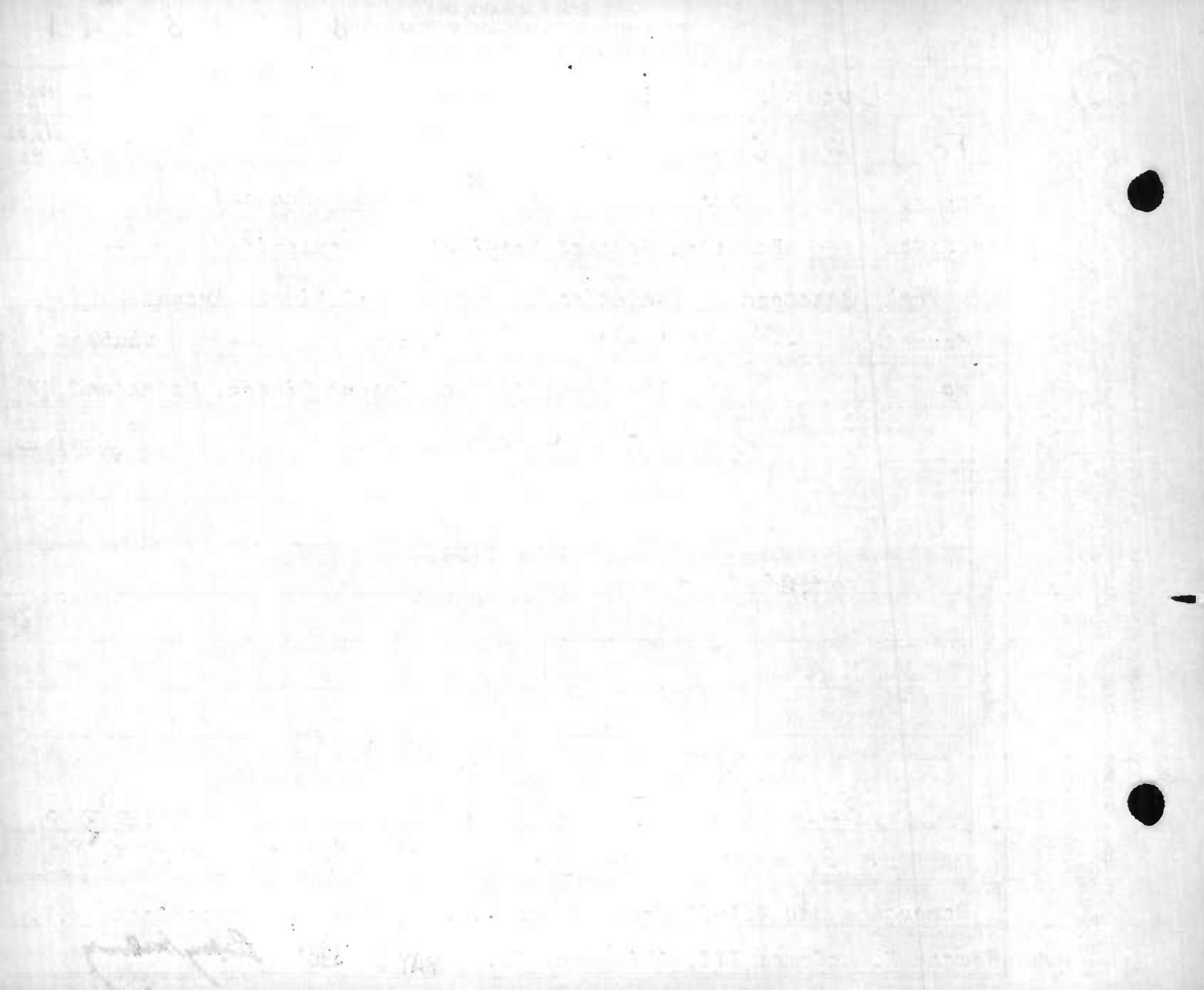
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 13441					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR 12:22 P.M.	
Lucille Marie Gibson												<input checked="" type="checkbox"/>	5-3	1981			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9c. DATE Pronounced Dead		2d. DATE MONTH DAY YEAR		2d. HOUR 12:32 P.M.	
Fe		W		6-26-17		63 yrs.		MONTHS		DAYS HOURS MIN		5-3 1981					
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH								
Penns.			USA			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Harford								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Fallston			Fallston General Hospital			Housewife			--								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
New York			Saratoga			Waterford			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			18 Sidney Avenue					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			17. INFORMANT			ADDRESS		
Kenneth			-- Landt			Mary			NO			James Joseph Gibson, Waterford, NY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Hypertension</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <u>Samuel H. Henck</u>			M.D.			TITLE (SPECIFY) <u>Deputy</u>			MEDICAL EXAMINER			DATE SIGNED <u>5/3/81</u>					
EXAMINER'S NAME (TYPE OR PRINT)			EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			ADDRESS			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Removal May 4, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Mason & Son F.H.			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Howard K. McComas III, Abingdon, Md.						MAY 5 - 1981			<u>Henry Henck</u>								
BP																	
DHMH-17 (VRA15 ME(5))																	
15M 2/80																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8113442					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
LORETTA MARION			GIVLER			05 06 81			05 06 81		245 PM						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
FEMALE			W			MONTH 01 DAY 02 YEAR 10			71			MONTHS DAYS		IF UNDER 24 HRS			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.					
PA.			U.S.						HARFORD COUNTY			MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK, NOT WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
FALLSTON			FALLSTON GENERAL HOSPITAL			Housewife XXXXXX											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			Fountain		
MD.			HARFORD			BEL AIR						7 NORTH FOREST GREEN Road					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
			Joseph	Nicholas	Hufnagle	Lida			NO			WARREN GIVLER			Fountain		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
3989						RHEUMATIC HEART DISEASE											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
DEMYELINATION			CONVAL. FAILURE														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
—			—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>May 7 6</u> , 1981, to <u>May 7 6</u> , 1981, that (I) (we) last saw the deceased alive on <u>May 7 6</u> , 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			A.J.			22e. ADDRESS			FAIRFAX General HOSP.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY			STATE		
Burial			May 9, 1981			BelAir Memorial Gardens, BelAir, Harford Md.											
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. MEDICAL EXAMINER'S SIGNATURE								
Howard K. McComas III, Abingdon, Md.						MAY 8 - 1981											

1960-1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 4 3			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
SARAH JANE GORGAS									05-20-81			11 ¹⁸ AM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE			White			MONTH 03 DAY 18 YEAR 17			67			MONTHS	MONTHS	DAYS	HOURS
7a. BIRTHPLACE (CITY, STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
PA (PENNSYLVANIA)			U. S. A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD COUNTY						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY			STAMP DEALER			
FALLSTON			FALLSTON GENERAL HOSPITAL			OWNER RETIRED									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland		HARFORD		BEL AIR		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			103 BRIGHT OAKS DRIVE						
14. FATHER'S NAME			MIDDLE			15. MOTHER'S MAIDEN NAME									
John Jacob			Keilen			First Mary Middle JANE Last HAF									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Unknown			NO			190-01-009			John GORGAS			103 BRIGHT OAKS DR, BEL AIR, MD			
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												COMPLETE HEART BLOCK			
4149 (b) SICK-SINUS SYNDROME															
4149 (c) ISCHEMIC HEART DISEASE															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 20 May 1981 to 20 May 1981, that (I) (we) last saw the deceased alive on 20 May 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Marilyn J. MacLure			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 20 May 81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marilyn J. MacLure			22e. ADDRESS FALLSTON GEN. HOSPITAL CEMETERY												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 22, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Cemetery			23d. LOCATION CITY OR TOWN Chamberlain, Franklin Co., PENNA.			COUNTY		STATE	
24. FUNERAL DIRECTOR Joseph William Foster ADDRESS Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR 20 May 1981			25b. REGISTRAR'S SIGNATURE									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ^{unless 3} should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

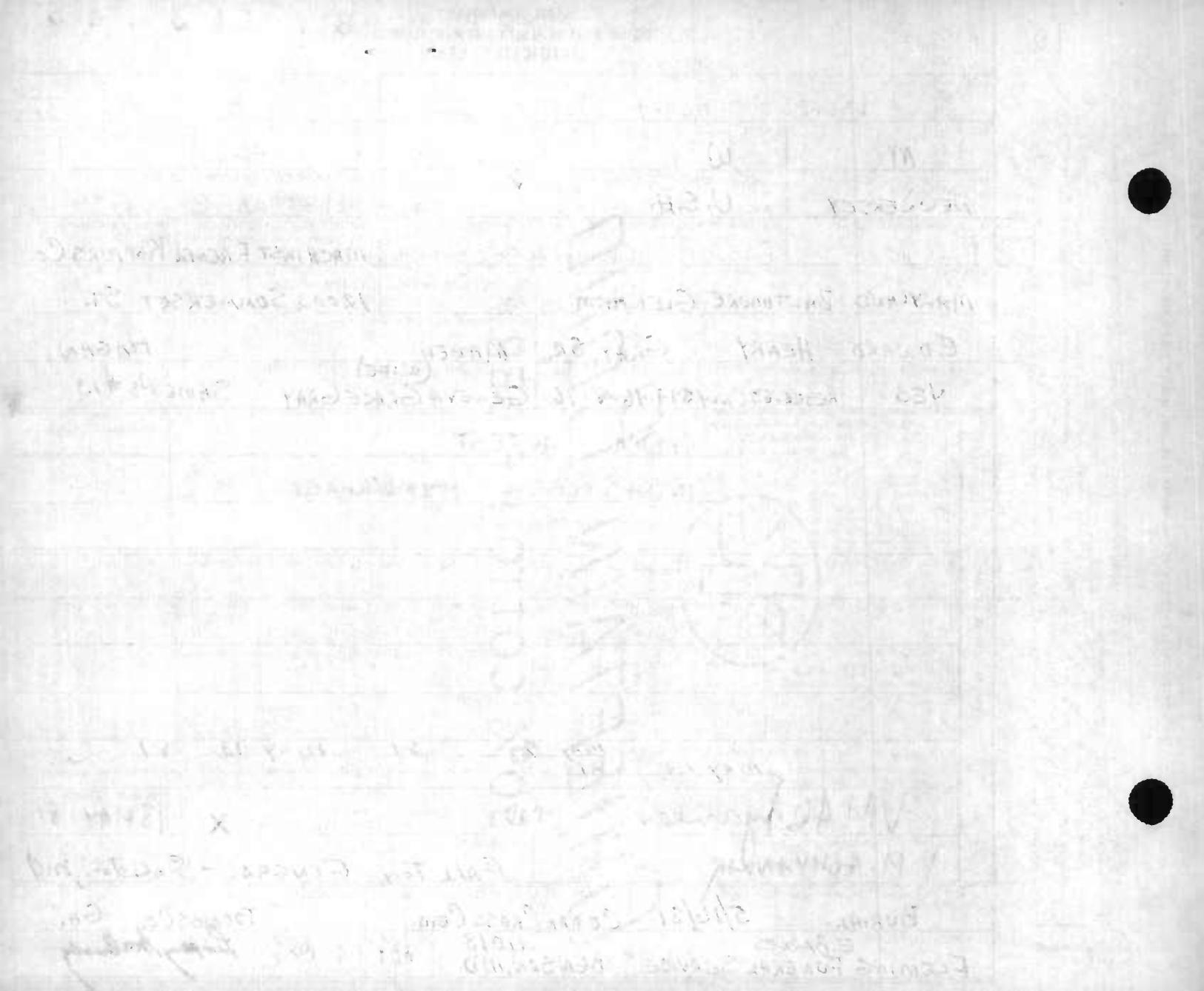
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	4	4
												REG. NO.						
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
			ORVILLE LEE GRAFTON						5-24-81						P 12:45 M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			White			MONTH DAY YEAR			67			MONTHS	YEARS	MONTHS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD						
Maryland			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
HARFORD			HARFORD MEMORIAL HOSPITAL			PATIENT - PAINTER			CONSTRUCTION									
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Md			HARFORD			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1/202 Prospect Hill Rd.									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT (IF OTHER) 734-6404 ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
FIRST MIDDLE LAST JAMES Oldfield GRAFTON			FIRST MIDDLE LAST DESSIE MINNICK			217-12-5666			Mrs. Mary E. Caudill 1910 CARSINS Road									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			19. DUE TO, OR AS A CONSEQUENCE OF (b)			20. DUE TO, OR AS A CONSEQUENCE OF (c)			21. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
IMMEDIATE CAUSE (a) 1990 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Cerebro respiratory arrest - Cardiac Vascular accident			Carcinomatosis			Neural injury									
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 4-27, 1981, to 5-24, 1981, that (I) (we) last saw the deceased alive on 5-24, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE M. J. Grafton, MD.			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED 5-24-81						
22e. ADDRESS 615 S. Union Ave Rd 6, 1921038																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 27, 1981			23c. NAME OF CEMETERY OR CREMATORIAL DEER CREEK METHOD. CEM.			23d. LOCATION CITY OR TOWN Forest Hill, HARFORD CEN. STATE Maryland 21050									
24. FUNERAL DIRECTOR Joseph William Foster 113 Broadway & Williams St. ADDRESS Bel Air, Maryland 21014									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	4	5
												REG. NO.						
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									MONTH	DAY	YEAR	2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			5 13 81			3:20 3PM			
EDWARD HENRY GRAY, Jr.																		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
M			W			MONTH 7 DAY 18 YEAR 34			46 YRS.			MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
NEW JERSEY			U.S.A.						WILMINGTON COUNTY									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
FALLSTON			FALLSTON GENERAL HOSPITAL			MACHINIST FOREMAN			KOPPERS CO.									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
MARYLAND			BALTIMORE			GLENARM			YES <input type="checkbox"/> NO <input type="checkbox"/>			12002 SOMMERSET ST.						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME															
EDWARD HENRY			MABEL															
FIRST MIDDLE LAST			FIRST MIDDLE LAST															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
YES			RESERVES ONLY 519-46-8196			(WIFE)			GENEVA GRACE GRAY			SAME AS #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4310 DUE TO, OR AS A CONSEQUENCE OF (b) INTRACEREBRAL HAEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from MAY 9, 1981, to MAY 13, 1981, that (I) (we) last saw the deceased alive on MAY 13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED									
V.M. ABHYANKAR			MD						13 MAY 81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
V.M. ABHYANKAR			FALLSTON GENERAL - Fallston, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE						
BURIAL			5/16/81			CEDAR CROSS CEM.			TOOMBS CO., GA.									
24. FUNERAL DIRECTOR NAME			ADDRESS			21018			25a. DATE REC'D. BY REGISTRAR			25b. FEE/CHARGE'S SIGNATURE						
E. BARNES									MAY 14 1981			Fleming, Barnes						
FLEMING FUNERAL SERVICE			BENSON, MD.															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-767-2626.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8113446													
REG. NO.																									
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
			MARIA			EDITH			HARDY						5-25-81			140		A M					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH			YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			IF UNDER 24 HRS							
FEMALE			WHITE			4 - 84 - 00						81			YRS.			MONTHS		DAYS		HOURS		MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Penns.			U. S. A.						HARFORD			Fallston			Fallston General Hospital			Housewife			212 RT				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
MD.			HARFORD			FALLSTON			YES			409 WHITAKER MILL, Rd.			PETER - TURNER			ANNIE - SHIPPY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ALYCE H. REASON			ADDRESS 21402 11 DORTER RD. ANNAPOLIS, MD.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			213-01-3986																		months				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												19. DUE TO, OR AS A CONSEQUENCE OF (b) Acute renal failure ?(c)													
2080 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												21. DUE TO, OR AS A CONSEQUENCE OF (c) Acute leukemia or leukemic reaction 2° occult													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IN EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE										
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on 5/27/81, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.												22b. SIGNATURE Dean L. Jarav													
22c. DEGREE MD												ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 5-25-81				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE				
cremation			5/26/1981			Green Mount						Baltimore, MD													
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																			
Molle Funeral			MAY 27 1981			Edgar Hardy																			

(a) $\sin x = \frac{1}{2}$ for $x \in [0, \pi]$

БІОГРАФІЧНА РОДОДАЧА \times МІСЦЕВІ СИРКИ. 64

11515 - TURNER, JOHN - 241954

65415 21300 438931 00 2 1966-13-816 24

10

Prakash and Asthana

RECORDED BY R. L. BROWN

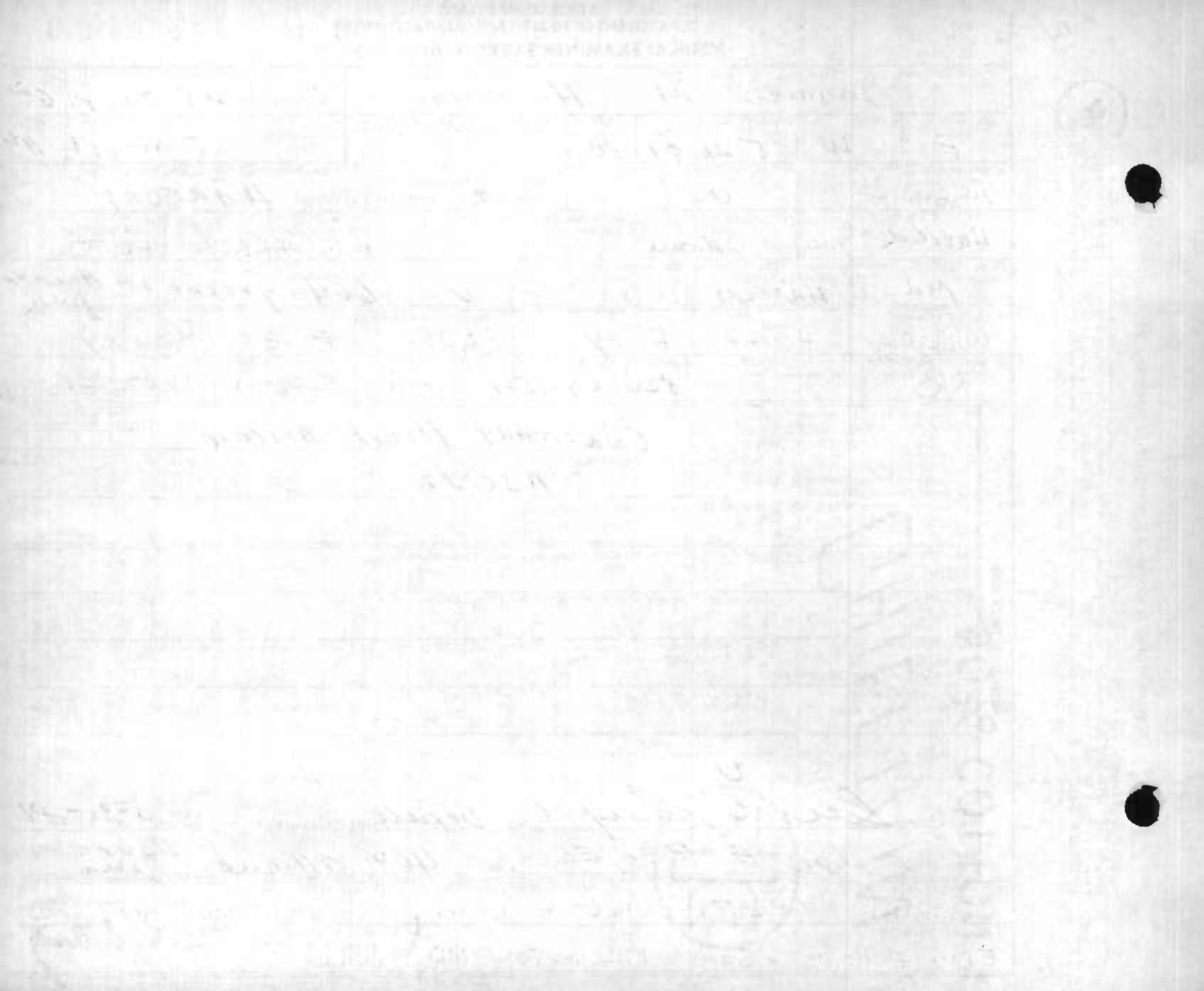
ENRAGE

RECORDED BY R. L. BROWN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL/CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

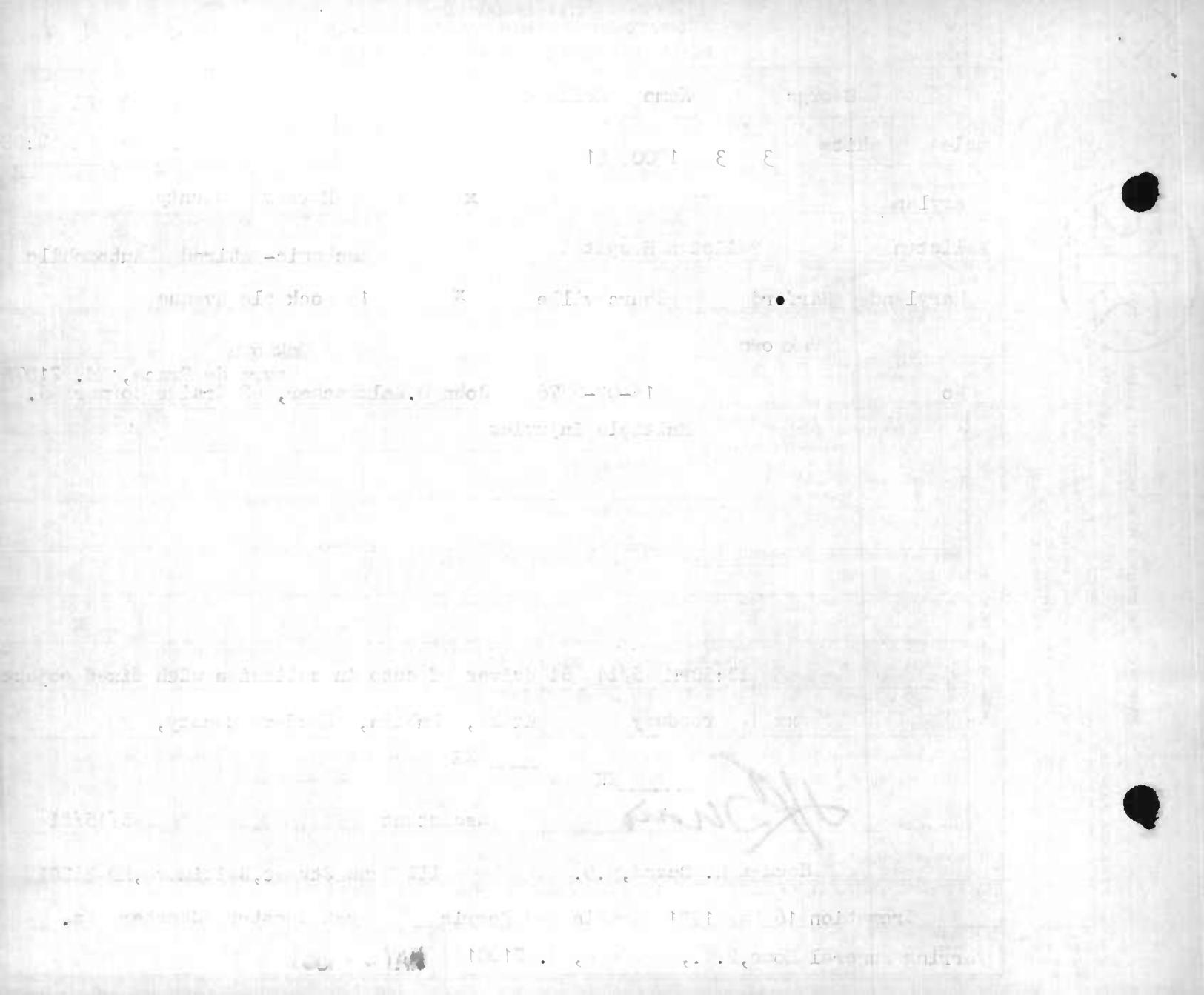
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 13448	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Janie M. Hickman						4	5	30	19	81	6 AM		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
F	W	5 26 01 80	80 yrs.			5	30	19	81	11	AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		USA						HARFORD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
HARFORD SUE		Home			Home maker			Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Md		HARFORD		HAURE DE GRAS		YES <input checked="" type="checkbox"/>		664 Greene St HARFORD					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		16. SOCIAL SECURITY NO.					
WILLIAM		HENRY		RILEY		SARAH ELIZ.		820-04-1561					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				ADDRESS			
NO						Coronary Heart Disease							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)				ASCUV9							
		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Luis E. Renjel				TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER				DATE SIGNED 5-30-81	
EXAMINER'S NAME (TYPE OR PRINT)		Luis E. Renjel				ADDRESS 464 Allard. HARFORD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
BURIAL		6-3-81		CHESTER cem			CHESTERTOWN		BENTON		MD		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
EDW Fellows & SON		MILLINGTON MD		JUN 11 1981		John B. Murphy							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 3 4 4 9							
1. DECEASED NAME (TYPE OR PRINT)			FIRST George			MIDDLE Kemp			LAST Hoffman			7a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> 5 14 1981	MONTH 5	DAY 14	YEAR 1981	7b. HOUR 2:08 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 3 DAY 3 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 81		7. IF UNDER 1 YR. MONTHS 0		8. IF UNDER 24 HRS. DAYS 0		9. DATE PRONOUNCED DEAD <input type="checkbox"/> 5 14 81		MONTH 19	DAY 14	YEAR 81	10. HOUR 2:08 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		PM									
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic-Retired			12b. KIND OF BUSINESS OR INDUSTRY Automobile					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 10 Rockdale Avenue									
14. FATHER'S NAME FIRST Unknown			15. MOTHER'S MAIDEN NAME FIRST Unknown														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-03-2976			17. INFORMANT ADDRESS Havre de Grace, Md. 21078 John W. Kalmbacher, 862 Craigs Corner Rd.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY: 8150 Multiple injuries										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } DUE TO, OR AS A CONSEQUENCE OF																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c) DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:50PM 5/14 1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto in collision with fixed object											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET Rt136, Dublin, Harford County, MD			CITY OR TOWN Harford County, MD			COUNTY MD			STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE 										TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.										ADDRESS 111 Penn Street, Baltimore, MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 16 May 1981			23c. NAME OF CEMETERY OR CREMATORIAL Cratin and Ferris			23d. LOCATION CITY OR TOWN West Chester			COUNTY Chester			STATE Pa.		
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001										25a. DATE REC'D. BY REGISTRAR MAY 6 U 1981			25b. REGISTRAR'S SIGNATURE 				
DHMH-17 (VR A15 ME (5)) 15M 2/80																	



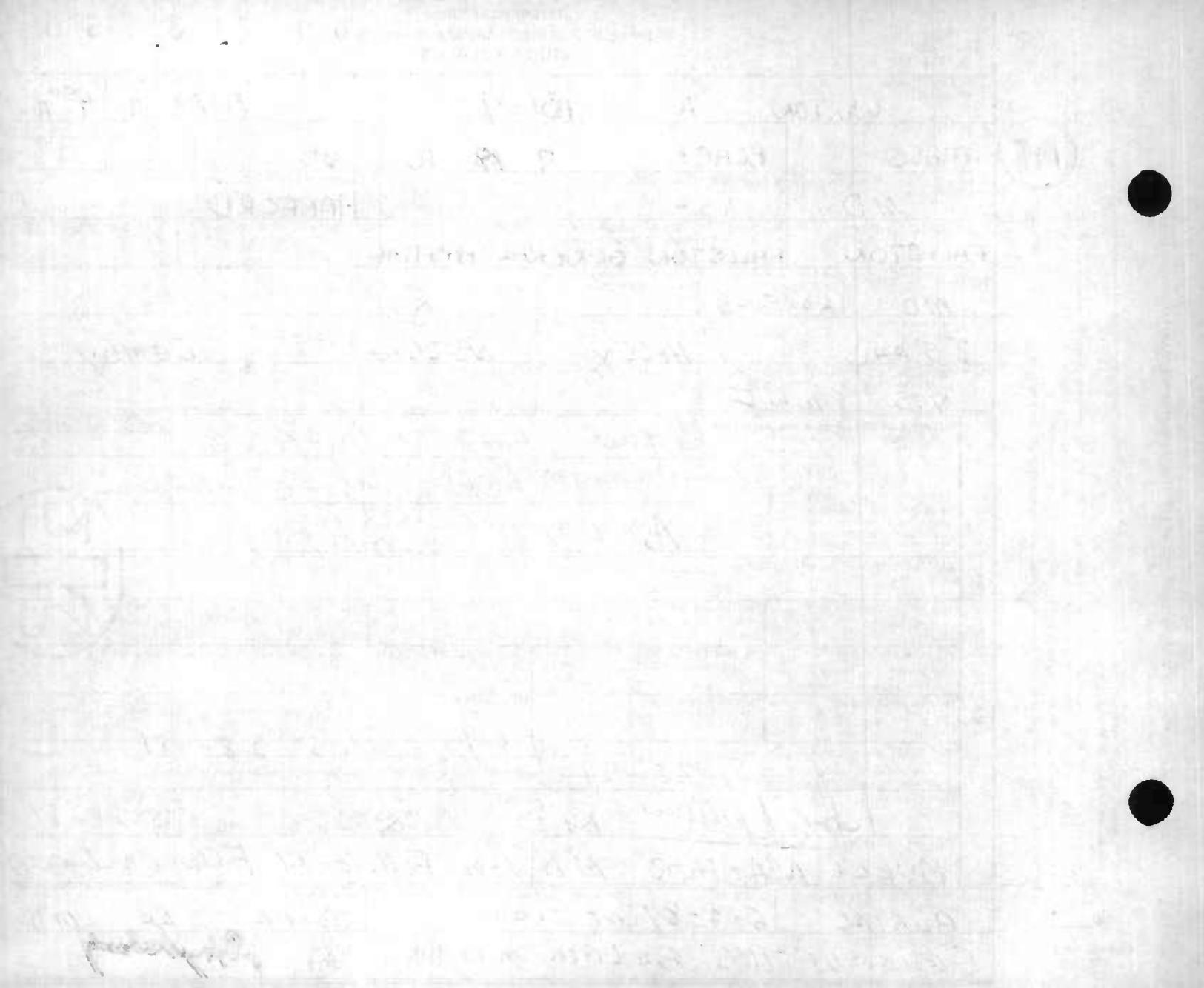
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

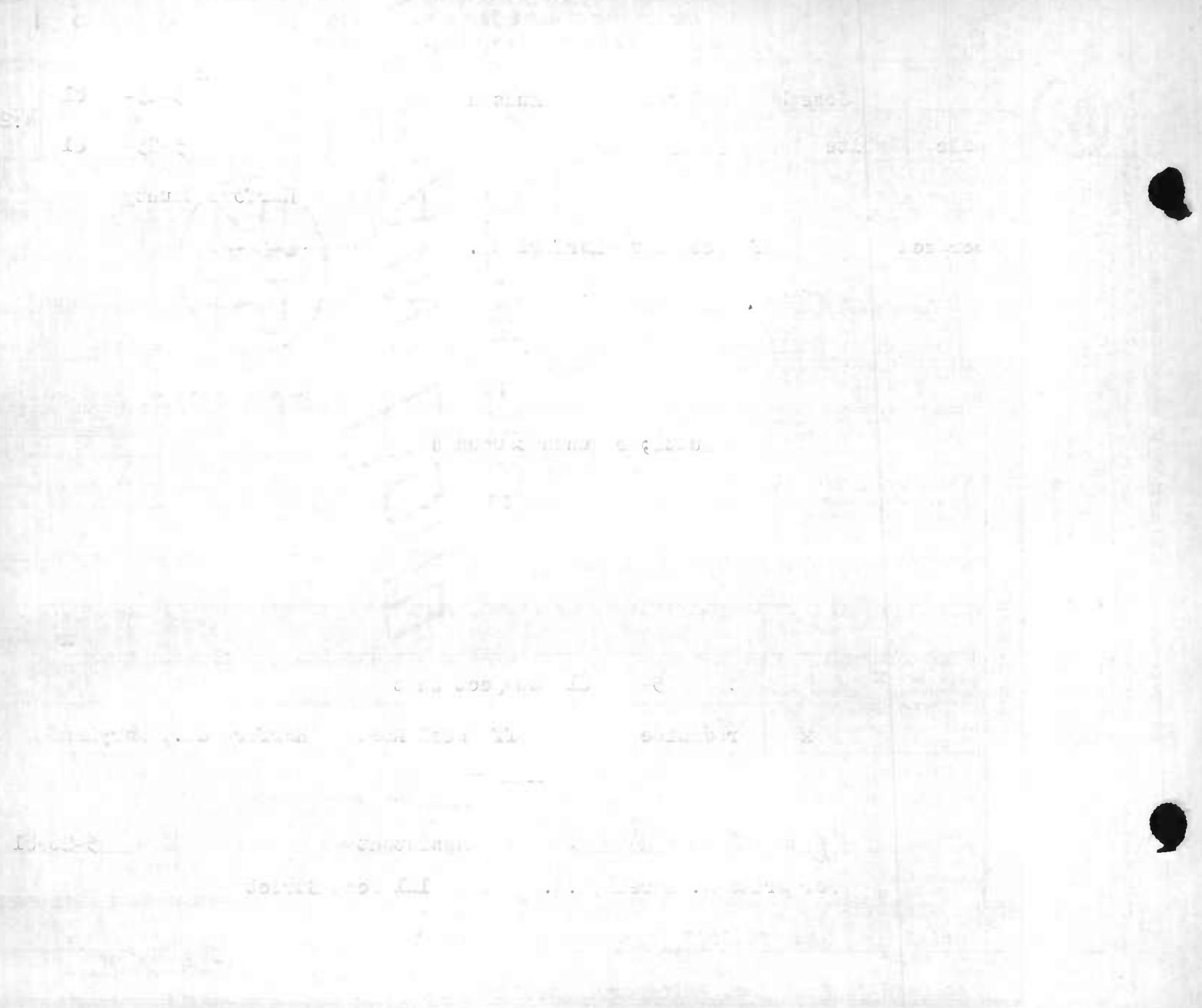
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	3	4	5	0									
												REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR								
WINTON A HOLLY												5 28 81						45A M								
3. SEX MALE			4. RACE BLACK			5. DATE OF BIRTH MONTH 7			DAY 19			YEAR 15			6. AGE (IN YEARS LAST BIRTHDAY) 65			IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			10. CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY MD.					
13a. STATE MD			13b. COUNTY HARFORD			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS														
14. FATHER'S NAME ISAAC			LAST HOLLY			15. MOTHER'S MAIDEN NAME NELLIE			16. SOCIAL SECURITY NO. YES WW II			17. INFORMANT			ADDRESS DEMBy											
18. CAUSE OF DEATH (Enter only one cause per line for item (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629												Respiratory Arrest 20 Duct cell Ca						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Due to, or as a consequence of (b) Left lung & Pulmonary Carcinoma & COPD														
Due to, or as a consequence of (c) ABCD & COPD																										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE											
22a. I certify that (I) (this hospital) attended the deceased from 5-24-81, 1981, to 5-28-81, 1981, that (I) (we) last saw the deceased alive on 5-28-81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE MURLI MATHUR, MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-28-81																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MURLI MATHUR, MD			22e. ADDRESS 1305 Fallston Rd; Fallston, Md-2067			23d. LOCATION CITY OR TOWN JOPPA			COUNTY HA			STATE MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-2-81			23c. NAME OF CEMETERY OR CREMATORIAL MT ZION			23d. LOCATION CITY OR TOWN JOPPA			COUNTY HA			STATE MD											
24. FUNERAL DIRECTOR NAME GEORGE W TITHE			24b. ADDRESS BEL AIR MD			24c. DATE REC'D. BY REGISTRAR JUN 9 1981			24d. REGISTRAR'S SIGNATURE John W. Kelly																	
BP																										
DHMH-16 30M 2/80 (VRA 15, 4)																										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												345				
												REG. NO.				
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI. MONTH DAY YEAR			2b. HOUR				
			Joseph Mallison			Hudson Jr.			<input checked="" type="checkbox"/> 5-25- 81			14:29				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD				
male		white		July 29, 1950		30 yrs.						5-25- 81				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			USA						Harford County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Aberdeen			Off Wheel Road-Harford Co.									Entertainer				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Md.			Harford		Long Bar Harbor			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Long Bar Harbor Camp Grounds						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Joseph Mallison Hudson Sr.			Eleanor E. Miller													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
no						Mrs. Eleanor E. Hudson			1216 E. Cold Spring							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) DUE TO, OR AS A CONSEQUENCE OF																
(c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?				
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5- 81			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) roadside			21f. LOCATION STREET Off Wheel Road			CITY OR TOWN Harford Co., Maryland							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/>			Inspection <input type="checkbox"/>			Inquiry <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			M.D.			Assistant			MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)			Margarita A. Korell, M.D.			ADDRESS			111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE				
Burial			May 29, 1981			Meadoeridge Memorial			Dorsey			Howard Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Leonard J. Ruck Inc. Baltimore, Maryland						MAY 28 1981										
BP																
DHMH-17 (VR A15 ME (5))																
15M 2/80																



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3452

1. DECEASED NAME (TYPE OR PRINT)			FIRST Anthony	MIDDLE James	LAST Imbrogulio	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5 29 81	MONTH 19	DAY 81	YEAR M	2b. HOUR 2d HOUR 5:18A	
3. SEX male	4 RACE white	5. DATE OF BIRTH MONTH 12	DAY 17	YEAR 49	6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County			MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Harford Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 2009 Christian Street, 21223				
14. FATHER'S NAME Samuel		MIDDLE James	LAST Imbrogulio	15. MOTHER'S MAIDEN NAME Rachel		MIDDLE M.	LAST Reynolds				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-52-9503			17. INFORMANT Rachel M. Imbrogulio			ADDRESS 2009 Christian St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF 8147 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH ? P.M. 5/29		YEAR 1981	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) pedestrian struck by truck			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET I-95	CITY OR TOWN Abingdon, Harford County,			COUNTY MD	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Hormez R. Guard</i>											DATE SIGNED 5/29/81
EXAMINER'S NAME (TYPE OR PRINT)		M.D.			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06-02-81		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park			23d. LOCATION CITY OR TOWN Baltimore City			COUNTY Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR JUN 1 1981			25b. REGISTRAR'S SIGNATURE <i>Hubbard</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-tran's permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										81113453						
										REG. NO.						
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		May 17, 1981			1:45am			
Thomas Briley Jenkins																
3. SEX			4. RACE			5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			Negro			MONTH Sept. 7, 1896		DAY	YEAR	84			MONTHS		DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.					Harford			Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Forest Hill			Rock Spring Road			Chauffeur			School bus							
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. Box 1					
14. FATHER'S NAME FIRST Charles			MIDDLE			LAST Jenkins		15. MOTHER'S MAIDEN NAME FIRST Carrie			MIDDLE Elizabeth		LAST Hill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-18-3284			17. INFORMANT Marcella Smith			ADDRESS same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1889										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)										DUE TO, OR AS A CONSEQUENCE OF Chronic Brain Syndrome and Senility						
(c)										DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Bladder with						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Left lower leg (below knee) amputation.										DUE TO, OR AS A CONSEQUENCE OF						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Jan. 26/81, 19 _____, to May 17/81, 19 _____, that (I) (we) lost saw the deceased alive on March 11/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE R.W.Bartel										DEGREE						
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED 5/18/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Barthel M.D.			22e. ADDRESS 2501 Rocks Rd., Forest Hill, Md. 21050													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/20/1981			23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery			23d. LOCATION CITY OR TOWN Forest Hill, Harford, Md.			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz			ADDRESS Jarrettsville, Md.							25a. DATE REC'D BY REGISTRAR MAY 20 1981			25b. REGISTRAR'S SIGNATURE			

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16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

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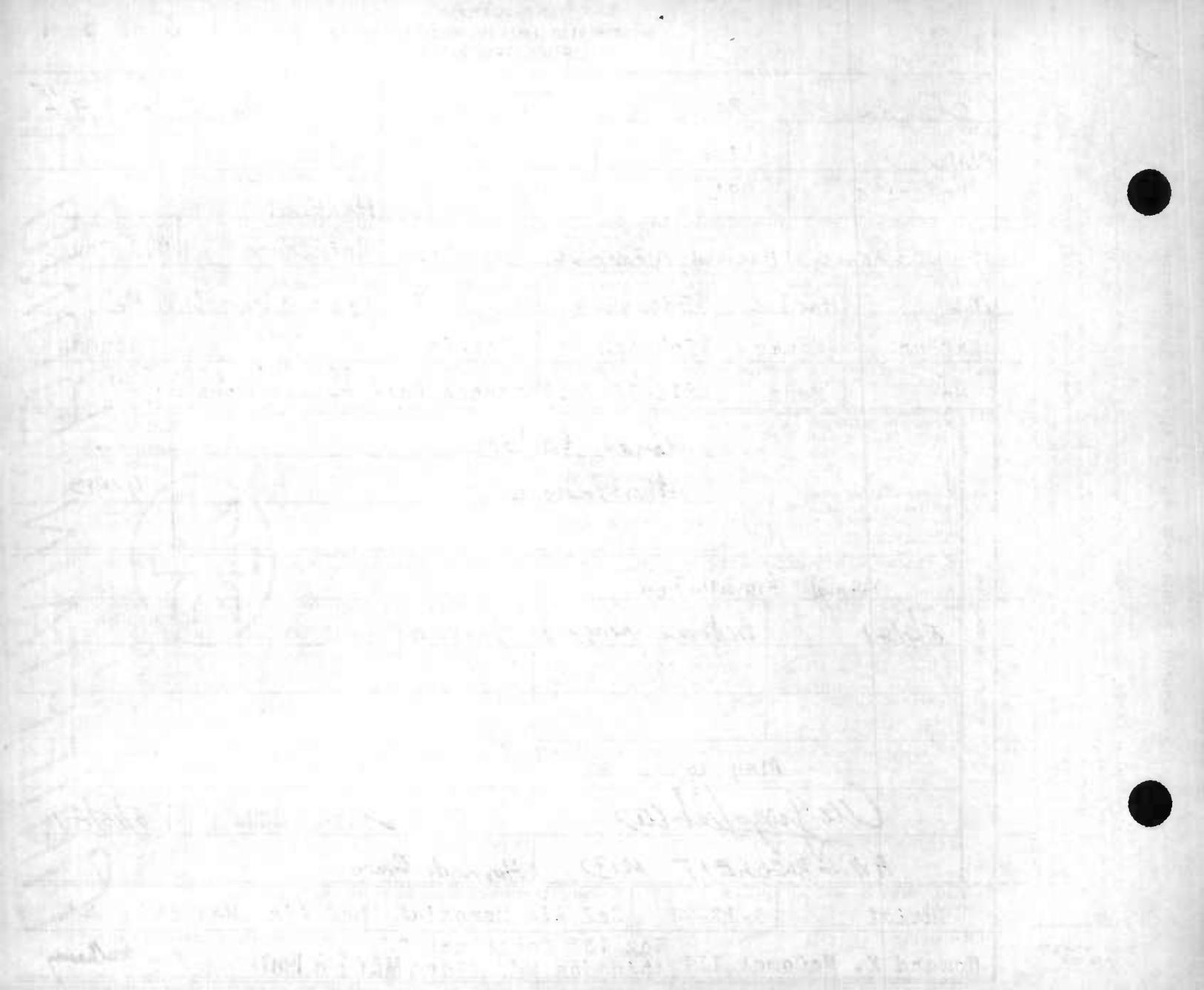
288 289 290 291 292 293 294 295 296 297 298 299 299 299 299 299

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/trust point. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or police called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 5 4					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
CLARENCE			Ray						Johnson			May 15, 1981				9 A M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			white			MONTH 10 DAY 24 YEAR 08			72			MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Nebraska			USA									Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Harford Grace			Harford Memorial Hospital			Maintenance			U.S. Govt.								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md			Harford			Edgewood			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1402 Columbiaview Rd.					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
FIRST Arthur			MIDDLE Henry			LAST Johnson			FIRST Jennie			MIDDLE			LAST Freeman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			1622 ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			None			212-16-9921			Frances Basl			Michelle Ct.			Forest Hill, Md. 21050		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Renal failure																	
4409																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b) Atherosclerosis																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
9 9			5/1/81			Intramural gangrene of cecum			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 7, 1981, to May 15, 1981, that (I) (we) last saw the deceased alive on May 15, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE: <i>Allegroletta</i> DEGREE:																	
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																	
22c. DATE SIGNED: 5/15/81																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
A.W. GRIGOLETTI MD			Harford Grace														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE					
Burial			5-18-81			Bel Air Memorial			Bel Air			Harford Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Howard K. McComas III			Box 137 Cokesbury Rd. Abingdon, Md. 21009			MAY 18 1981			<i>Henry McCrady</i>								



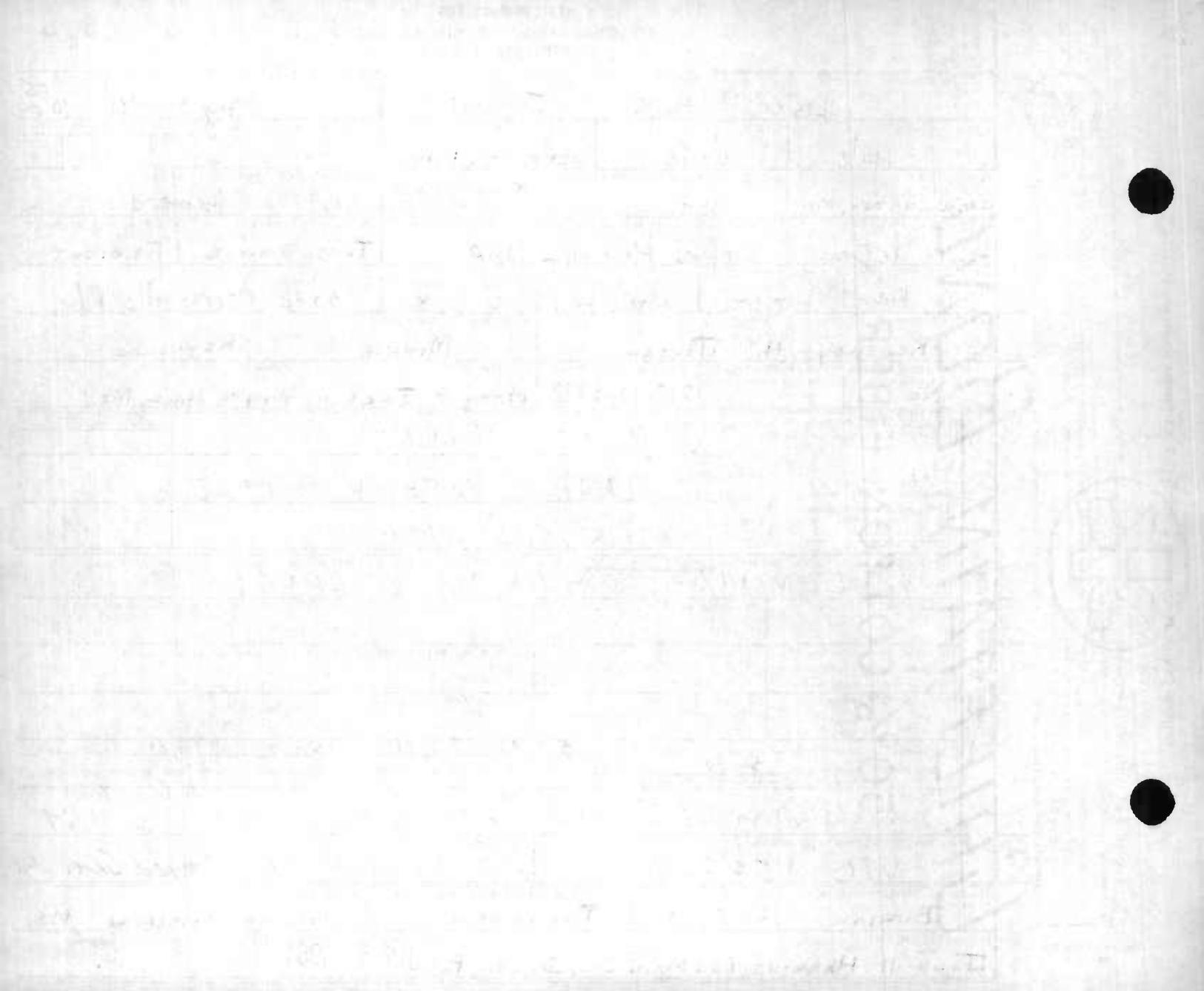
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	5	5
												REG. NO.						
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									MONTH	DAY	YEAR	2b. HOUR			
(TYPE OR PRINT)			Lister Hayes Jordan									May 30 1981		35	10 pm			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			white			MONTH DAY YEAR SEPT. 23, 1914			66			MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		HOURS				
DARLINGTON, MD.			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford			MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Harve de Grace			Harford Memorial Hosp									TRUCK DRIVER			FREIGHT			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Md.			Harford			White Hall			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			5326 Norrisville Rd						
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME												
REVERDY			H. JORDAN			MINNIE						REYNOLDS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No			217-12-6278			MARY B. JORDAN, WHITE HALL, MD.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																		
(b) CARDIAC ARREST																		
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE																		
(c) METERIO SCLEROSIS																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
PNEUMONIA, CARCINOMA OF LUNGS																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 5-22, 19 81, to 5-30, 19 81, that (I) (we) last saw the deceased alive on 5-30, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 5/31/81						
22b. SIGNATURE Dante Monakil												DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL												22d. ADDRESS 622 UNION AVE, HARVE DE GRACE MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE BURIAL 6-3-81			23c. NAME OF CEMETERY OR CREMATORY TABERNACLE			23d. LOCATION CITY OR TOWN WHITEFORD HARFORD			23e. COUNTY MD.						
24. FUNERAL DIRECTOR NAME JOHN H. HARKINS, 600 MAIN ST., DELTA, PA.			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 5 1981			25b. REGISTRAR'S SIGNATURE Dante Monakil									
BP																		
DHMH-16 30M 2/80 (VRA 15, 4)																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove certain portions. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

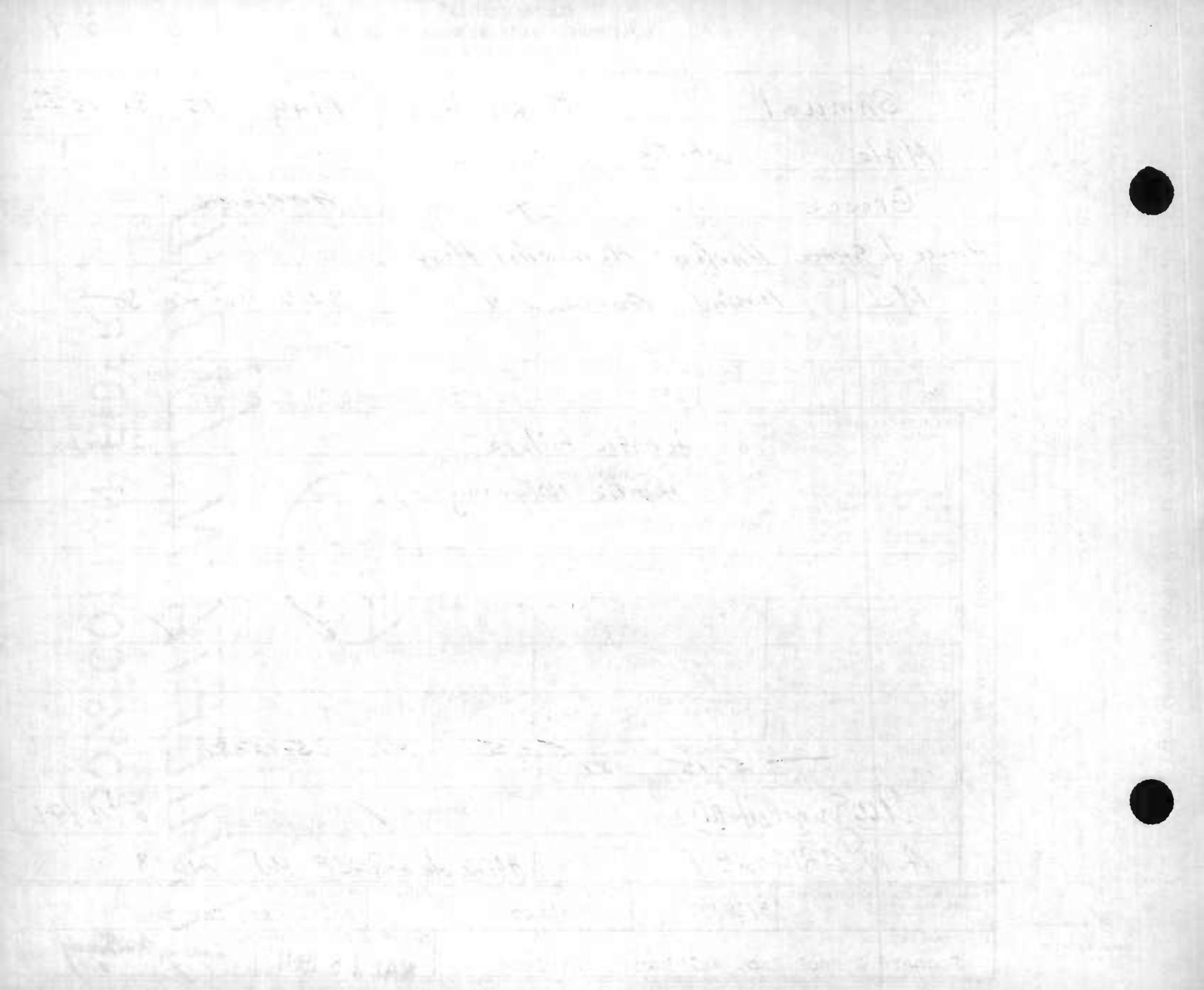
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	5	6
												REG. NO.						
1. DECEASED NAME TYPE OR PRINT			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
WILLIAM EARL									KALMBACHER, SR.			5-20-81			2:15	M	P	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
MALE			WHITE			9 13 1910			70			MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			USA						HARFORD									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
HARFORD DE GRACE			HARFORD MEMORIAL HOSPITAL			Mechanic/Retired			Automotive									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Md.			HARFORD			Aberdeen						1204 N. STEPNEY Rd.						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
FIRST Alec			MIDDLE Kalmbacher			LAST Mary			215-03-6616			Florence R. Kalmbacher, 1204 North Stepney Rd.			Aberdeen, Md. 21001			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			17. DUE TO, OR AS A CONSEQUENCE OF (b)			18. DUE TO, OR AS A CONSEQUENCE OF (c)			19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
N.			Cardiac Arrest			Terminal			4029			HASCVD			20 yr.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET P.P.R.			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-20-81</u> to <u>5-20-81</u> , that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (she) (he) (did not) view the body after death.																		
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Perryman			Harford			Maryland			5-21-81			
Peter Rodman, M.D.			8 Low St. Aberdeen, Md. 21001															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE			
Burial			23 May 1981			Spesutia Episcopal			Perryman			Harford			Maryland			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Tarring Funeral Home, P.A., Aberdeen, Md. 21001						1981												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 5 7			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Samuel			S				Keryches		May 15		81	32	10 P M	10 ³²	
3. SEX			4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS AT BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White		Month Day Year		Aug 16, 1896		84		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Greece			U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Harford County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Havre de Grace			Harford Memorial Hosp		Retired Chef										
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Md			Harford		Abberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		326 Cooke St						
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
?					Keryches		Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No			219-03-2913		Mr Mark Bennett		Aberdeen, Md								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
1552 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												?			
(b) Hepatic Malignancy															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					<input checked="" type="checkbox"/>		<input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5-5, 19 81, to 5-15-81, 19, that (I) (we) last saw the deceased alive on 5-15, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here.)												22c. DATE SIGNED 5/16/81			
22b. SIGNATURE A. W. Grigoleit			DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. W. Grigoleit			22e. ADDRESS		Havre de Grace Md		21678								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/19/81		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood		23d. LOCATION CITY OR TOWN Baltimore, Maryland		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland			ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 18 1981		25b. REGISTRAR'S SIGNATURE L. J. Ruck Inc.								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be contacted at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	3	4	5	8		
										REG. NO.							
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
			Elsie R. Kirby						May 29, 1981			M					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female			White			Feb. 1, 1908			73 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland			U.S.A.						Harford County			MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Jarrettsville			3206 Longwood Court						Housewife								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland						Baltimore						3901 Forrester Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Nathan			Gladys Sewell														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			213-36-1852A			Mrs. Verna Lashley, 3901 Forrester Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
1991 Metastatic Carcinoma of the Liver: Primary																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c) DUE TO, OR AS A CONSEQUENCE OF 26 unknown																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Rafael Hernandez</i>																	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)										22d. ADDRESS							
Rafael Hernandez, M.D.										7401 Osler Drive							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Mem. Gardens			23d. LOCATION CITY OR TOWN Bel Air			COUNTY Harford		STATE MD			
Burial			6/2/81														
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc. 5305 Harford Rd. 21214										"JUN 1 1981					<i>Linda Ruck</i>		
ADDRESS																	

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 3 4 5 9

1. DECEASED NAME (Type or print) Jennie Amanda Cohee Kirk				First	Middle	Last	2a. DATE OF DEATH Month 5 Day 12 Year 81	2b. HOUR 5:00 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 1-27-1900			6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford County			Md.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brooks Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived at institution: Residence before admission) STATE: Maryland COUNTY: Cecil		13c. CITY OR TOWN Georgetown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Gen. Del.		
14. FATHER'S NAME First B. Franklin Cohee Sr.		Middle	Last	15. MOTHER'S MAIDEN NAME Ada Lillian Hicks		Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16b. SOCIAL SECURITY NO. 217-52-8046		17. INFORMANT Suzanne Long		Address 400 Sandy Bottom Rd. East		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE 		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/12/81			
22d. PHYSICIAN'S NAME (Type) GUNTHER D. HIRSCH, M.D.		22e. ADDRESS 131 S. UNION AVE. HAVRE DE GRACE						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-15-81	23c. NAME OF CEMETERY OR CREMATORIAL Galena Cem.			23d. LOCATION (City or Town) Galena		
24. FUNERAL DIRECTOR FELLOWS FUNERAL HOME - BOX 176 - MILLINGTON, MD.		ADDRESS 216 51			25a. REG'D BY REGISTRAR 507	25b. REGISTRAR'S SIGNATURE 		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 6 0					
												REG. NO.					
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			NORMA			J. KIRKWOOD			5 16 81						10 45 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE			White			MONTH DAY YEAR			51			MONTHS	YEARS	MONTHS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Ohio			U.S.A.									Harford County			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Fallston			Fallston GEN. HOSPITAL						Homemaker								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Harford			Joppa						662 Shore Drive					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME											
			Henry E. Seibert			Catherine						E. Affolter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No			212-26-7542			Robert H. Kirkwood-Joppa, MD. 21085						1 hr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>																	
4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															1/2 hr		
(b) <i>probable myocardial infarction</i>																	
(c) <i>Aspirin</i>															1/2 hr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>16 May</i> , 19 <i>81</i> , to <i>16 May</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>16 May</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>T.E. Harrison</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>T.E. Harrison</i>			22e. ADDRESS <i>FGD</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/20/1981			23c. NAME OF CEMETERY OR CREMATORIAL Holly Hill			23d. LOCATION CITY OR TOWN White Marsh			COUNTY			STATE Maryland		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue			ADDRESS Dundalk, MD. 21222			25a. DATE REC'D. BY REGISTRAR MAY 19 1981			25b. REGISTRAR'S SIGNATURE <i>John Duda-Ruck</i>								

Geographia

170 19 22 40 SWW SWIMMER

170 19 22 40 SWW SWIMMER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

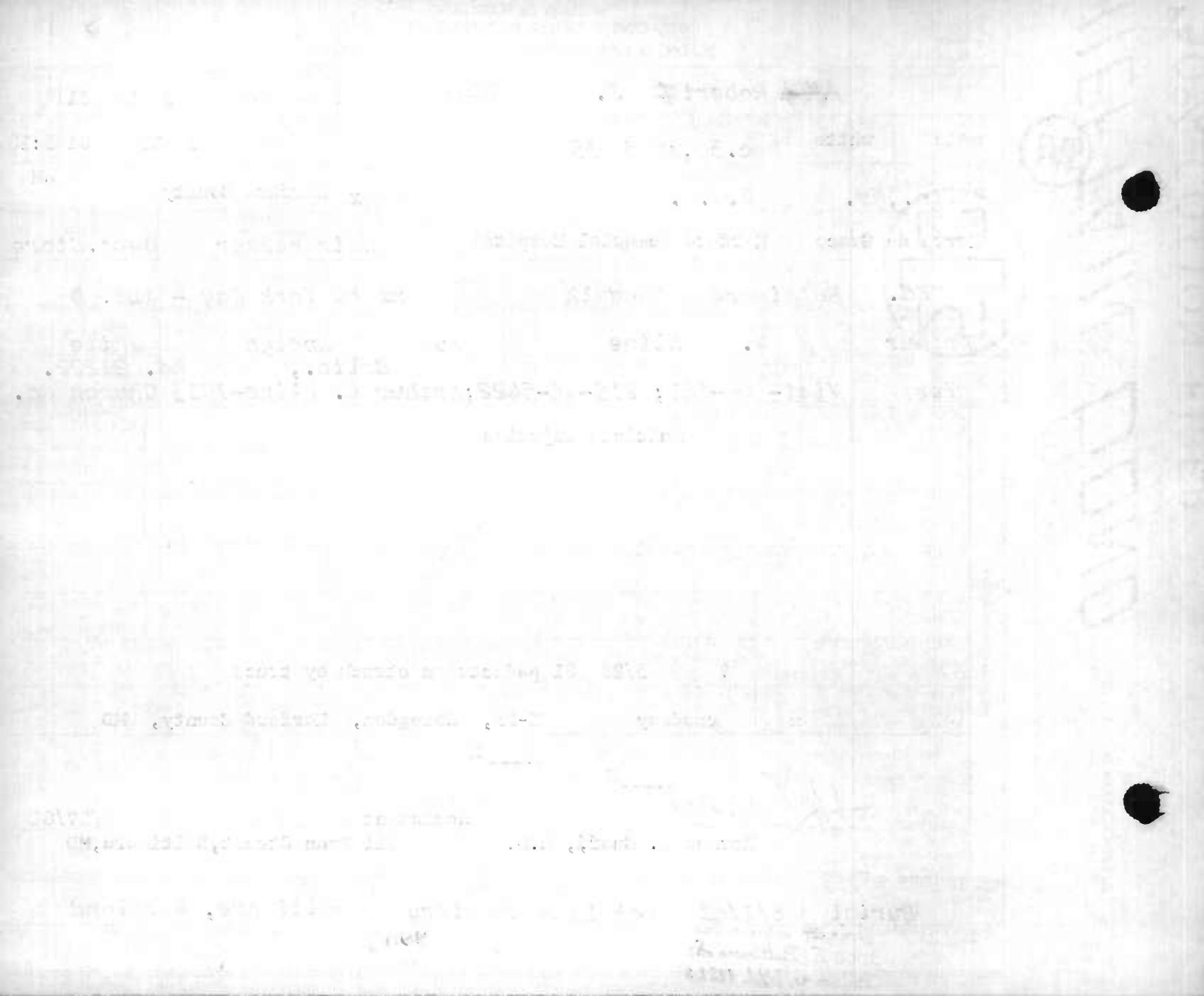
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 4 6

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR	
Robert J. Kline						<input checked="" type="checkbox"/>	5	29	1981	5:18 M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
male	white	Dec. 30, 1945	35 yrs.	MONTHS	DAYS	HOURS	5	29	1981	5:18 M	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH Harford County				
Balto..Md.		U.S.A.			<input type="checkbox"/>	<input type="checkbox"/>	AM				
11. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Harford Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
					Hairdresser			Dept. Store			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 86 York Way - Apt. D				
14. FATHER'S NAME FIRST Arthur		MIDDLE W.	LAST Kline	15. MOTHER'S MAIDEN NAME Eva Evelyn White							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Balto., Md. 21222.							
Yes		Viet-'64-'67; 215-46-5422; Arthur E. Kline-1913 Church Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) } DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). 21a. DATE OF OPERATION											20d. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		21c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5/29 1981			21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by truck			
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21h. LOCATION STREET I-95, Abingdon,			CITY OR TOWN Harford County, MD			COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											22b. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.											DATE SIGNED 5/29/81
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 6/1/81		23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Maryland				COUNTY STATE
24. FUNERAL DIRECTOR NAME John H. Moran, Inc. 3000 E. Baltimore St.		25a. DATE REC'D. BY REGISTRAR JUN 1 1981			25b. REGISTRAR'S SIGNATURE						



O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page

retained by the hospital or offending physician.

retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director for future reference.

11. DEATH CERTIFICATE: This certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

12. MEDICAL RECORDS: These records should be filed with the hospital or attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 3 4 6 2

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
KNOERLEIN, FREDERICK						5/1/81				10:15 AM	
3. SEX	4 RACE		5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
m	w		Sept. 19 1894				84	YRS	IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore, Md.		U.S.A.						HARFORD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
FALLSTON		Fallston General Hospital			Policeman			Balto. City			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
11a. STATE	11b. COUNTY	11c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			13f. ADDRESS		
Maryland		Baltimore				3341 Kenyon Ave. 21213			2816 Calvary Rd		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						BelAir, Md. 21014		
FIRST Lawrence Knoerlein			MIDDLE LAST			FIRST Bridget			MIDDLE N/A		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			220-36-1653			Helen Schenning			2816 Calvary Rd		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>											
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DOUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>											
DOUE TO, OR AS A CONSEQUENCE OF (c) _____											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>DIABETES MELLITUS</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE		DEGREE			22c. DATE SIGNED						
V.M. ABHYANKAR		MD			ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	1 May 1981			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
V.M. ABHYANKAR MD		FALLSTON GEN. HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		4 May 81		Gardens of Faith		Baltimore		Baltimore		Md.	
24. FUNERAL DIRECTOR NAME		Schimunek Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
3331 Brehms La., Balto., Md.		21213			MAY 5 1981		F. Schimunek				

1981-2-YAN

1981-2-YAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	1	3	4	6	3				
										REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
WILBERT			WELDON KNOTTS			5 12 81			11	00	PM									
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)								
MALE			CAUCASIAN			07 08 08			72			IF UNDER 1 YEAR								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH								
W. Va.			U. S. A.						HARFORD			FALLSTON								
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STATE								
FALLSTON GENERAL Hospital			Laborer			Steel			13c. CITY OR TOWN			13b. COUNTY								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT								
Joseph			Ida May (unknown)			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			530-01-6816			Mrs. Florence Knotts, Joppa, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			PART 1. DEATH WAS CAUSED BY: 4100 Cardiovascular Arrest			ADDRESS								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on			5/12 1981			to			19			, that (I) (we) last			22b. SIGNATURE Joseph Barnard					
above, (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL BelAirMem. Gardens			23d. LOCATION CITY OR TOWN BelAir			COUNTY Harford			STATE Md.					
Burial			May 16, 1981																	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Linda McComas											
						MAY 14 1981														

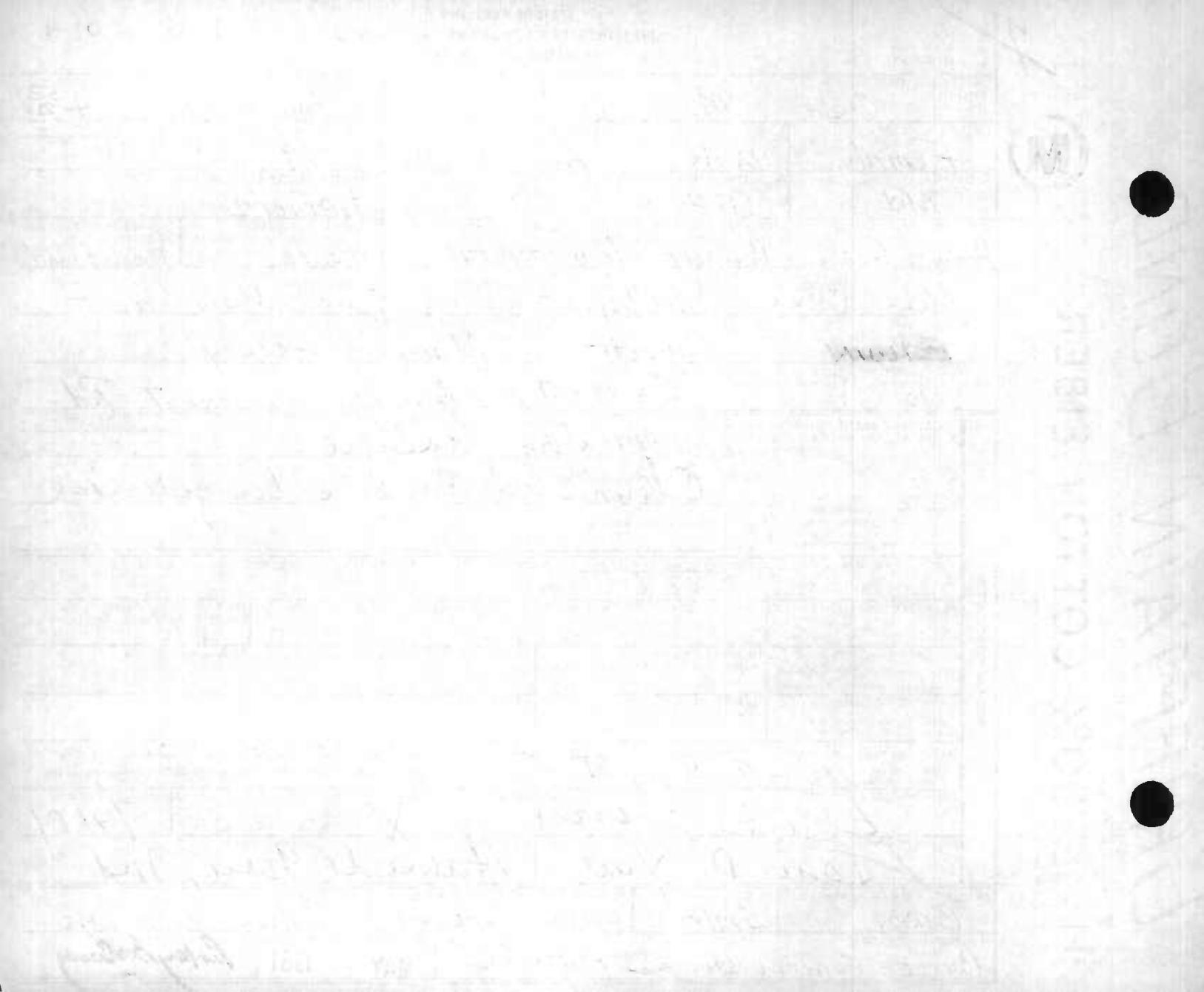


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 20 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	6	4	
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Orela			M.			Leslie						May 4 1981						4:53 PM	
1. SEX:			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			MONTH DAY YEAR			April 11 1902			79			MONTHS DAYS		HOURS MIN.		
7. BIRTHPLACE COUNTRY			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH									MD				
Md			USA			Hartford													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY							
Haven de Grace			Hartford Mem Hospital			owner						Beautician							
13a. STATE Md			13b. COUNTY Cecil			13c. CITY OR TOWN Port Deposit			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 12 S Main Street							
14. FATHER'S NAME Edwin			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Mary			LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 313-74-1537			17. INFORMANT F.G. Arntz			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			ADDRESS 129 FOREST Rd			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
									DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive lung disease										
									DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3-2, 1981, to 5-4, 1981, that (I) (we) last saw the deceased alive on 5-4, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE E. SOUN D. Yun			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/4/81										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Haven de Grace, Md																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/7/81			23c. NAME OF CEMETERY OR CREMATORIAL LORRAINE Park Cem			23d. LOCATION CITY OR TOWN Woodlawn			COUNTY		STATE					
24. FUNERAL DIRECTOR NAME BURGEE Funeral Home 3631 Falls Road -			ADDRESS 21211			25a. DATE REC'D. BY REGISTRAR MAY 6 - 1981			25b. REGISTRAR'S SIGNATURE Lisa J. Bradley										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Postage may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 3 4 6 5 CERTIFICATE OF DEATH									
REG. NO.									
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST DAVID	MIDDLE LEE	LAST LOKEY	2a. DATE OF DEATH	MONTH 5-2-81	DAY 1
							YEAR 1981		2b. HOUR 8A M
3. SEX MALE	4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR NOV. 12, 1918			6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE COUNTRY Ala.	7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
10. CITY OR TOWN OF DEATH HARFORD DE BRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS HARFORD MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance			12b. KIND OF BUSINESS OR INDUSTRY School		
13a. STATE Md	13b. COUNTY PERRY	13c. CITY OR TOWN Perryville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Box 143 1050 Principio Fr-			
14. FATHER'S NAME FIRST George	MIDDLE SIMPSON	LAST Lokey	15. MOTHER'S MAIDEN NAME FIRST Fleda			MIDDLE Robertson	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II			17. INFORMANT Lily A. Lokey			ADDRESS Perryville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost. DOUE TO, OR AS A CONSEQUENCE OF (b) By progressive cerebral thrombosis due to, or as a consequence of cerebral thrombosis									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 109									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5-2-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John H. Wachman			DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/2/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Levin WACHMAN	22e. ADDRESS HARFORD DE BRACE, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-5-81	23c. NAME OF CEMETERY OR CREMATORIAL Hart's			23d. LOCATION CITY OR TOWN North East	COUNTY Cecil	STATE Md.		
24. FUNERAL DIRECTOR NAME Paul R. Bouch	ADDRESS North East, Md.			25a. DATE REC'D. BY REGISTRAR 5/5/81	25b. REGISTRAR'S SIGNATURE John H. Wachman				
DHMH-16 30M 2/80 (VRA 15, 4)									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8113466		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Roger L. Mays						05 01 81						10:00 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Cau		MONTH 03	DAY 08	YEAR 30	51			MONTHS YRS.	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. DATE OF BIRTH			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
VIRGINIA		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD Co.			Fallston				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. STREET ADDRESS				
Fallston General Hospital				MASTER MECHANIC			PIPE LINE			1849 POOLE ROAD				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			16. ADDRESS				17. INFORMANT			
FIRST GEORGE O. MAYS				FIRST OLIVE W. INSCOR			STELLA M. MAYS, DARLINGTON, MD.				ADDRESS			
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				19b. SOCIAL SECURITY NO.			19c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				19a. DATE OF OPERATION			
YES				118-26-3015										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				20. DUE TO, OR AS A CONSEQUENCE OF (b)			21. DUE TO, OR AS A CONSEQUENCE OF (c)				22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100				myocardial infarction										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				23. DUE TO, OR AS A CONSEQUENCE OF Hyper Tension										
21a. DATE OF OPERATION				21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/1/81 to 5/1/81, that (I) (we) last saw the deceased alive on 5/1/81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE A. B. MARTINS				23. DEGREE			24. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/1/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. B. MARTINS				22e. ADDRESS FALLSTON GENERAL HOSPITAL										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 5-4-81			23c. NAME OF CEMETERY OR CREMATORIAL BEL AIR MEM. Gdns.			23d. LOCATION CITY OR TOWN BEL AIR HARFORD			COUNTY STATE MD.	
24. FUNERAL DIRECTOR NAME John H. Hopkins Funeral Home				ADDRESS 800 Main St., Delta, Pa.			25a. DATE REC'D. BY REGISTRAR MAY 7 1981			25b. REGISTRAR'S SIGNATURE Henry McEvoy				
DHMH-16 25M (VRA 15, 4) 1/79														

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13467

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FRED MCCOLLINS			2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
						<input type="checkbox"/>	5-11-	81		10
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
male	black	Sept. 10, 1962	18 yrs.	MONTHS	DAYS	HOURS	MIN			10
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Ohio		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Harford County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Harve DeGrace		Harford Memorial Hospital			Student		Susquehanna/Chesapeake Job Corps			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	13f. ADDRESS			
Ohio		Jefferson	Stubenville	YES <input checked="" type="checkbox"/>		326½ Terrace Avenue	Susquehanna/Chesapeake Job Corp Center Port Deposit, Md. 21904			
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME				
Earmon				McCollins, Sr.		Barbara	Ann Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		278-70-4161		Robert Franklin						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		{		(b)						
DUE TO, OR AS A CONSEQUENCE OF		{		(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						2d. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Margarita A. Korell</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE
Burial		May 16, 1981		McIntyre Cemetery		McIntyre		Jefferson		Ohio
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
A. Patterson & Son		Perryville, Md. 21903		MAY 20 1981						

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1960-1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, should be detached for use as the burial-transit permit. Then please remove carbon paper, with the State Dept. of Health and Mental Hygiene. Prior to burial, cremation, or removal.

BP _____
DHMH-16 30A 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 3 4 6 8

REG. NO

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 10 A.M.	
IVA MARIE MELIS						5/29/81				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 80 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford		10. CITY OR TOWN OF DEATH FALLSTON	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --						
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Joppatowne			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 500 Trimble Road	
14. FATHER'S NAME FIRST (Unknown) MIDDLE -- LAST Curnett		15. MOTHER'S MAIDEN NAME FIRST Mattie MIDDLE -- LAST (Unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-24-8353		17. INFORMANT Mrs. Delores A. McCleary, Joppatowne, MD		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Severe Dehydration / malnutrition 2-3 mo. DUE TO, OR AS A CONSEQUENCE OF (c) CHF - ASCVD, HCVD yrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 AM 3:30 PM										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7 Hypertension ? Depression										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 20, 1981, to May 28, 1981, that (we) last saw the deceased on May 28, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE Albert S. C. Sun, M.D.		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 5/29/81			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S. C. Sun, M.D.		22f. ADDRESS 1800 Harford Rd. Fallston 21047								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 1, 1981		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery Hall		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE -- Md.		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.		25a. DATE REC'D. BY REGISTRAR JUN 1 1981		25b. REGISTRAR'S SIGNATURE Howard K. McComas III						

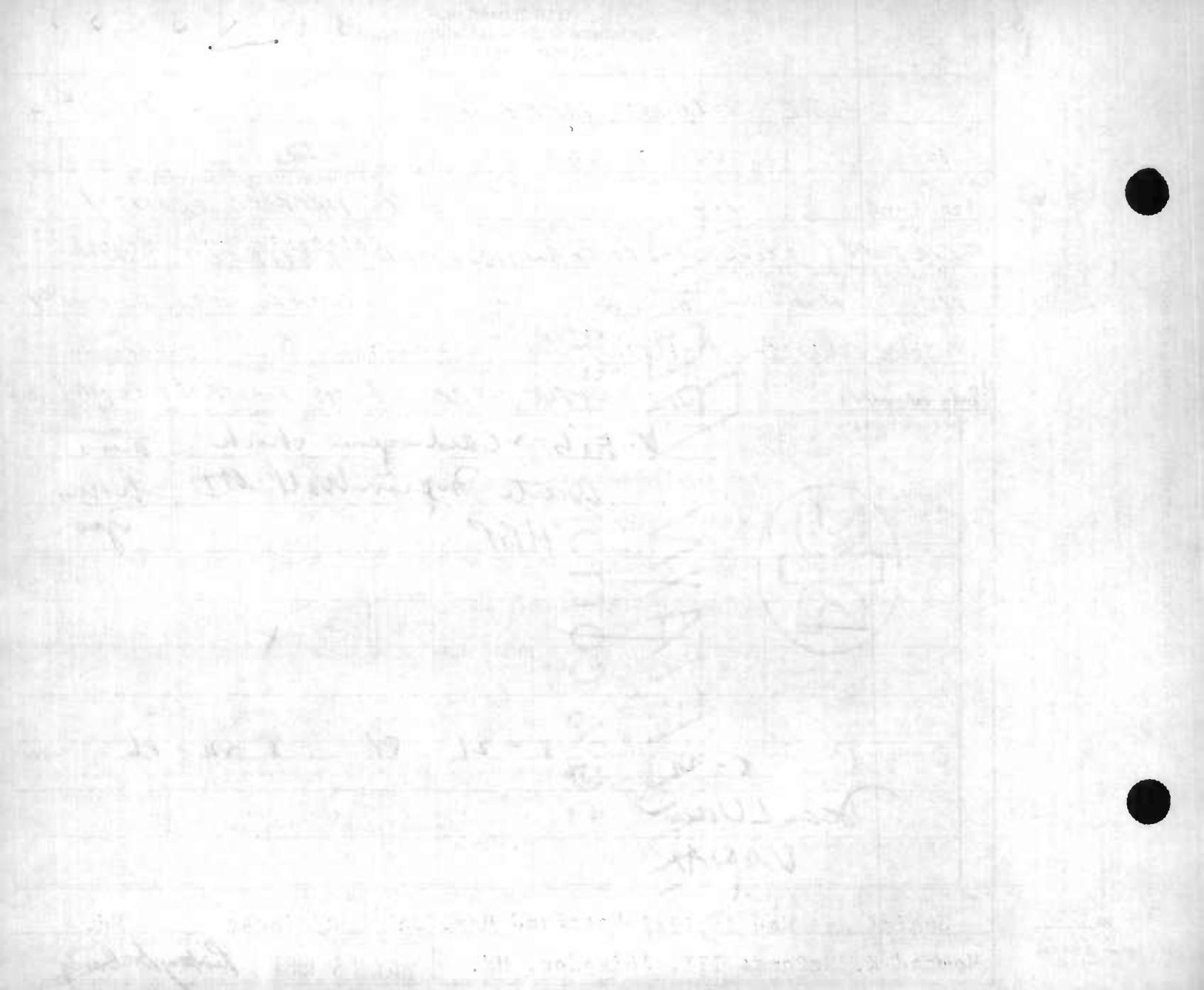
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked as 'Yes', any injury or either traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1 - FOR STATE REGISTRAR											REG. NO. 8 1 1 3 4 6 9		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
ELSIE M. Marie METZGER						05 21 81			11 40 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
F		W		MONTH 03 DAY 20 YEAR 09			72			MONTHS		DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U.S.					HARFORD COUNTY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR PRINT FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
FALLSTON		FALLSTON GENERAL HOSPITAL		CABINET RETIRED			SCHOOL						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b. STATE NO.		13b. COUNTY HARFORD		13c. CITY OR TOWN EBBINGWOOD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1719A FOUNTAIN ROCK WAY					
14. FATHER'S NAME													
FIRST John		MIDDLE Phillip		LAST Christian		15. MOTHER'S MAIDEN NAME Katherine		LAST Schneeman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) NO													
16b. SOCIAL SECURITY NO. 218 09 3740 PAT BROWN 1719A FOUNTAIN ROCK WAY EBBINGWOOD													
17. INFORMANT ADDRESS													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>V. Fib & Cardiogenic shock</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4100 <u>hrs</u> DUE TO, OR AS A CONSEQUENCE OF <u>acute Superior Wall MI.</u> <u>hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HBP</u> <u>yes</u> (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5-21-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>5-9-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Dean L. Jaun</u>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>VSSEAU</u>		22e. ADDRESS											
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 23, 1981		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Park			23d. LOCATION CITY OR TOWN Baltimore		COUNTY Md.		STATE		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.		25a. ADDRESS			25b. DATE REC'D. BY REGISTRAR MAY 26 1981			25c. REGISTRAR'S SIGNATURE <u>Patsy Kennedy</u>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3470				
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 5 DAY 21 YEAR 81									2b. HOUR M				
1. DECEASED NAME (TYPE OR PRINT)			FIRST Mary			MIDDLE ANN			LAST Mitchell			2c. DATE PRONOUNCED DEAD 5 22 81			2d. HOUR 2:30A	
3. SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Nov. 25 61			6. AGE (IN YEARS) LAST BIRTHDAY 19 yrs.			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH Aberdeen			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 715 and Penn Central RR			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE			12b. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAYREDE GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1234 BATTERY ST.						
14. FATHER'S NAME FIRST HOWARD			MIDDLE PEREY			LAST MITCHELL			15. MOTHER'S MAIDEN NAME FIRST JOAN			MIDDLE ETHEL			LAST SPOUSE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. -			17. INFORMANT Mrs. JOAN ETHEL MITCHELL-SAME										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia from ligature strangulation of neck DUE TO, OR AS A CONSEQUENCE OF 9630 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(b) DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY est. HOUR A.M. MONTH DAY YEAR 11:48 AM 5/21 19 81			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found strangulated										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) RR tracks			21f. LOCATION STREET RT. 715&PennCentral RR, Aberdeen, CITY OR TOWN COUNTY HARFORD Co, MD STATE										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> and in my opinion ACTUAL SIGNATURE Hormez R. Guard, M.D.												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				
23a. EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.												TITLE (SPECIFY) Assistant				
23b. ADDRESS 111 Penn Street, Baltimore, MD 21201												DATE SIGNED 5/22/81				
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23d. DATE MAY 26, 81			23e. NAME OF CEMETERY OR CREMATORIY Rock Run, CEM.			23f. LOCATION CITY OR TOWN HARFORD			COUNTY HARFORD, MD STATE				
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME HAYREDE GRACE			ADDRESS MD.			25a. DATE RECEIVED BY REGISTRAR 5/22/81			25b. REGISTRAR'S SIGNATURE							
BP																
DHMH-17 (VR A15 ME (5))																
15M 2/80																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

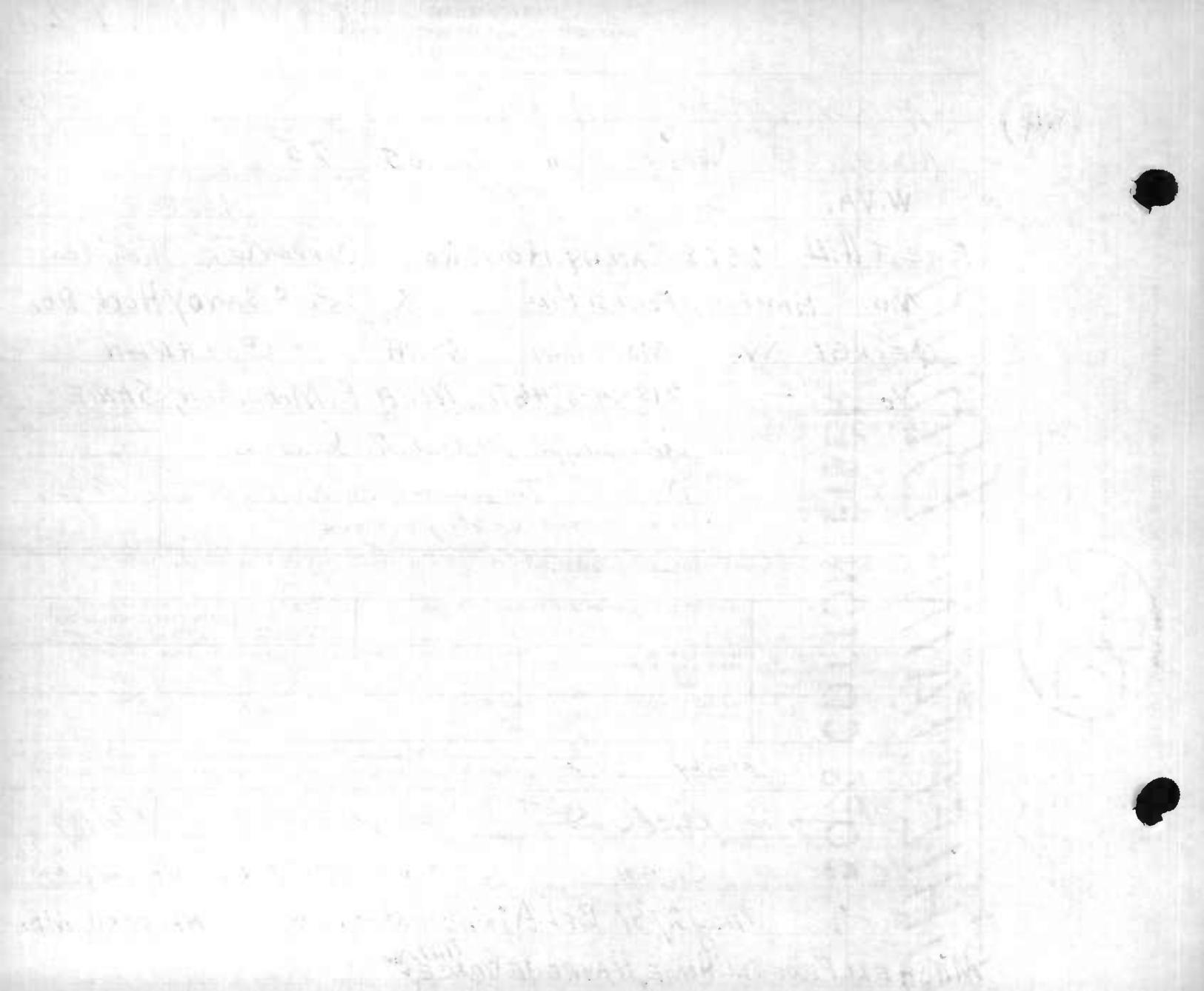
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	7	1
												REG. NO.						
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>OSSIE</u> MIDDLE <u></u> LAST <u>IRENE MOROSKO</u>			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
									5 6 81			3 20	P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH <u>9</u> DAY <u>21</u> YEAR <u>1928</u>			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS <u>52</u> DAYS <u>0</u>		HOURS <u>0</u> MIN. <u>0</u>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
FALLSTON			FALLSTON GENERAL HOSPITAL			Hairdresser												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Harford			Edgewood						1942 Melvin Drive						
14. FATHER'S NAME FIRST <u>Zeb</u> MIDDLE <u></u> LAST <u>Dorsett</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Ossie</u> MIDDLE <u>I.</u> LAST <u></u>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			1942 Melvin Drive						
NO			244-36-1705			Louis L. Morosko-Edgewood, MD. 21040												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF LIVER</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>						
5712 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ALCOHOLIC LIVER DISEASE</u>												10-20 yrs						
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>PROBABLE HEPATOCELLULAR CARCINOMA; PNEUMONIA; ENCEPHALOPATHY</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>												
22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Mark Diamond</u>			22c. DEGREE <u>MD</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>5/6/81</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
DIAMOND																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN <u>White Marsh</u> COUNTY <u>Maryland</u> STATE <u></u>									
Burial			5/9/1981			Holly Hill												
24. FUNERAL DIRECTOR NAME <u>Duda-Ruck, Inc.</u>			ADDRESS <u>7922 Wise Avenue Dundalk, MD. 21222</u>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>John J. Brady</u>									
						MAY 8 1981												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81 13472			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2b. DATE OF DEATH			REG. NO.
NORMAN O. MORRISON												MAY 24, 1981			
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH JULY 16, 1905			6. AGE (IN YEARS LAST BIRTHDAY) 75			2b. HOUR 8:00 P.M.			
7a. BIRTHPLACE W. VA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
10. CITY OR TOWN OF DEATH FOREST HILL			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 2508 SANDY HOOK, RD.			12a. USUAL OCCUPATION CARPENTER			12b. KIND OF BUSINESS OR INDUSTRY RETIRED						
13a. STATE MD.			13b. COUNTY HARFORD			13c. CITY OR TOWN FOREST HILL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2508 SANDY HOOK, RD.			
14. FATHER'S NAME GEORGE W.			15. MOTHER'S MAIDEN NAME NORA - COCHRAN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-14-8346			17. INFORMANT Mrs. NORA E. MORRISON, SAME									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1531 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pain. Cr. Transverse Colon involving stomach 1 1/2 yrs</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>at diaphragm</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>May 24</u> , 1981, to <u>May 24</u> , 1981, that (I) (we) lost the deceased alive on <u>May 24</u> , 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 5/25/81 21078			
22b. SIGNATURE <i>Henry H. Kwah</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY H. KWAH			22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE May 27, 1981			23c. NAME OF CEMETERY OR CREMATORIAL BEL AIR MEM. GARDENS			23d. LOCATION CITY OR TOWN HARFORD, MD.			23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <i>Mitchell Funeral Home, Havre de Grace, MD.</i>			
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME, HAVRE DE GRACE			ADDRESS NO. 1077 W. BEL AIR AV.												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

13473

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED	2b. MONTH	DAY	YEAR	2b. HOUR
Ira		Lincoln		Mullins				<input checked="" type="checkbox"/>	5	31	1981	M
35	35	35	35	35	35	35	35	35	35	35	35	35
1d. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. MONTH	DAY	YEAR	10. DATE PRONOUNCED DEAD	11. HOUR	12. HOUR	
Male	White	Jan. 1, 1938	43 yrs.	MONTHS	DAYS	MONTH	DAY	YEAR	5 31 1981	4:35	a.m.	
10a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10b. CITIZEN OF WHAT COUNTRY?	10c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10d. BALTIMORE CITY OR COUNTY OF DEATH									
W.Va.	USA		Harford County, MD.									
11. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
BelAir	1608 Conowingo Rd. - in auto				Owner Operator				Auto Parts			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS								
Maryland	Harford	BelAir		1608 Conowingo Road								
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST					
Orpha		Snowden	Mullins	Nora	Mae		Stidom					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS									
No	215-34-5307	Mrs. Edna Mullins, Bel Air, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Shotgun wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:05 <input checked="" type="checkbox"/> 5 31 1981	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in auto	21f. LOCATION STREET 1608 Conowingo Rd.	CITY OR TOWN Bel Air,	COUNTY Harford,	STATE MD.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
22b. TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial JUNE 3, 1981 BelAir Mem. Gardens Bel Air Harford Md.												
23b. DATE REC'D. BY REGISTRAR JUN 4 1981												
23c. LOCATION CITY OR TOWN Bel Air												
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.												
ADDRESS												
25a. REGISTRAR'S SIGNATURE												

BP _____
DHMH-17
(VR A15 ME (5))
15M 2/80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be identified or paged.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	1	3	4	7	4	
										REG. NO.							
1. FOR STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Cora E. Myers										May 8, 1981						5:42 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female			White			MONTH		DAY	YEAR	64			MONTHS	YEARS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Sparta			USA										Harford MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
Harford de Grace			Harford Memorial Hospital							Machinist/Retired U.S. Gov't							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland			Harford		Aberdeen			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			9 East Aztec Street						
14. FATHER'S NAME			FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			FIRST		LAST			
Everett							Reeves		Margaret					Crouse			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT		16d. ADDRESS			21001						
NO			168-14-2253			Watson E. Myers		, 9 E. Aztec St., Aberdeen, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
3481 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarct							
										DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral hypoxic damage							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE										DEGREE							
Anne E. Myers										ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED				
H. Y. Myers M.D. 319 E. Union Ave. Harford Grace													5/11/81				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			12 May 1981			Harford Mem. Gardens			Aberdeen, M.D., Harford Md.			118-21078					
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Tarring Funeral Home, P.A., Aberdeen, Md. 21001										MAY 18 1981			Signature				

Items #18a-22a Film G555 5/28/81 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3475

1-
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
JOHN			Robert	NEFF		<input checked="" type="checkbox"/>			5-8-	1981			
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
male	white	Nov. 29, 1936	44 yrs.	MONTHS	DAYS	HOURS	MIN		12:40	P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
N. Mexico		USA					Harford County			MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Edgewood		1987 Brookside Drive					Accountant			Accounting			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Harford		Edgewood				1987 Brookside Drive					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
Emery		Earl	Neff		Annabelle							Kreiger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes		1955-1956		509-28-4724		Mrs. Annabelle K. Neff, Galena, Kansas							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 5718 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant					MEDICAL EXAMINER		DATE SIGNED 5-9-81				
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.					ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Removal		May 8, 1981		Derfelt Funeral Home, Galena-Cherokee - Kans.									
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Howard K. McComas III, Abingdon, Md.				MAY 13 1981		F. McComas							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH-17
(VR A15 ME (5))
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAM 3. RETAIN PAGE 5 FOR YOU. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

ITEMS #5&6 Film G555 5/11/81 rc STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH					REG. NO. 1 3 4 7 6						
1. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES		MIDDLE B.		LAST NIXON		2a. DATE KNOWN TO ESTIMATED DEATH MONTH DAY YEAR 5-4- 81 19		2b. HOUR 13:50 P M	
3. SEX male	4. RACE white	5. DATE OF BIRTH Nov. 11, 1912 Dec. 11, 1912		AGE IN YEARS LAST BIRTHDAY 68 yrs.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-4- 81 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penns		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County	
10. CITY OR TOWN OF DEATH Edgewood		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 832-A Windstream Way		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 832-A Windstream Way			
14. FATHER'S NAME FIRST Charles		MIDDLE B		LAST Nixon		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE Catherine		LAST ?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. NW 11		16c. INFORMANT Mrs Elizabeth Nixon		17. ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 1:00 P.M. 5-4- 81 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) apartment		21f. LOCATION STREET 832A Windstream Way CITY OR TOWN Edgewood, Maryland COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 5-5-81					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/81		23c. NAME OF CEMETERY OR CREMATORIAL Most Holy Redeemer		23d. LOCATION CITY Baltimore, Maryland COUNTY STATE					
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc.		ADDRESS Baltimore, Maryland		25a. DATE RECEIVED BY REGISTRAR MAY 5 1981		25b. REGISTRAR'S SIGNATURE <i>John J. McNamee</i>					
BP		DHHM-17 (VR A15 ME (5)) 15M 2/80									

132

SUGAR

John W. Dugger

2004 2 483

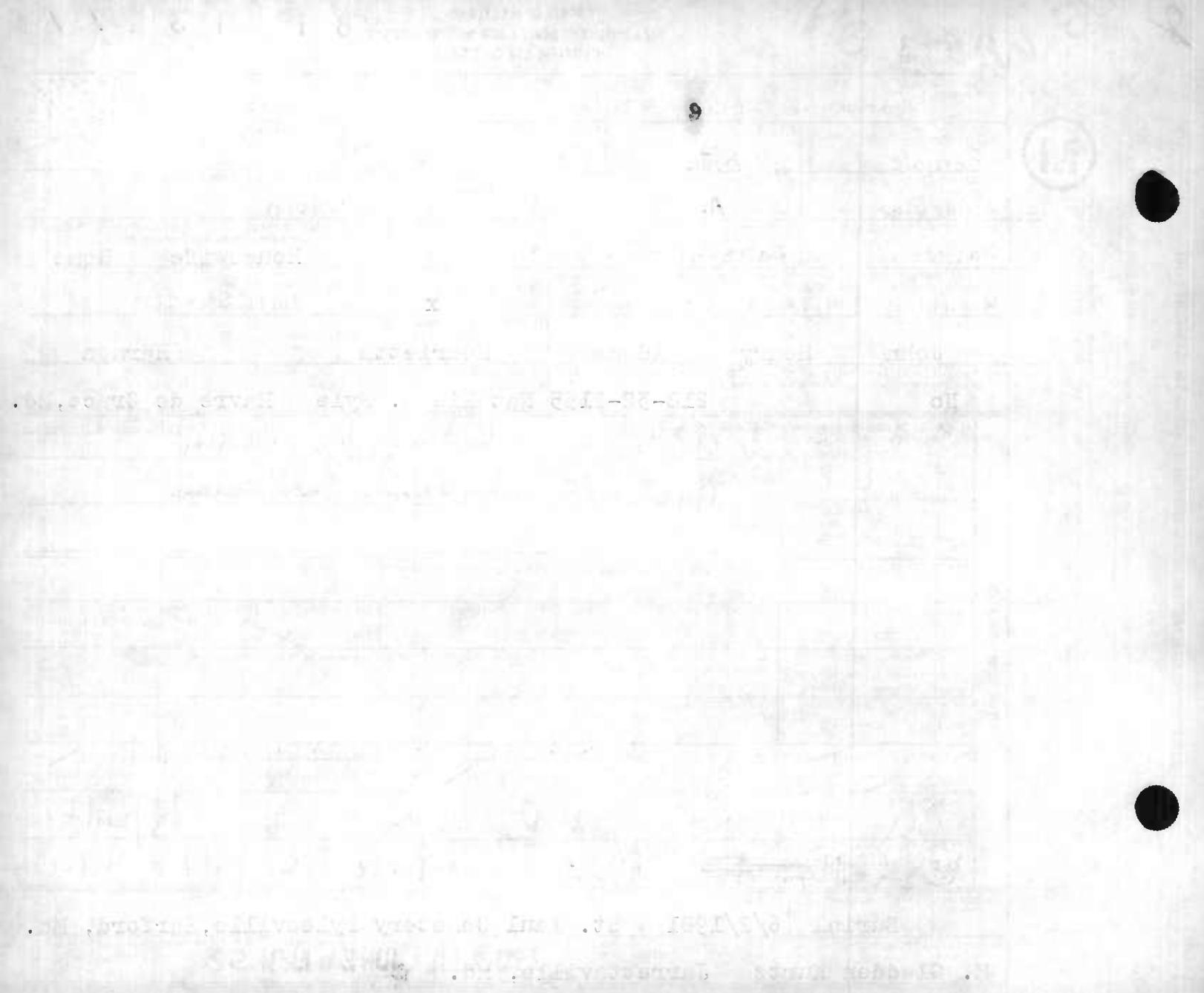
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 3 4 7 1							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Catherine May Pyle									May 29, 1981						5:50 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		# UNDER 24 HRS			
Female			White			MONTH 08 DAY 30 YEAR 02			78			MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.					
Maryland			U.S.A.						Harford			MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Fallston			Fallston General Hospital			none			Housewife			Home					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Harford			Bel Air			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			321 Wall Street					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
FIRST John MIDDLE Henry LAST Adams			Henrietta														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			218-32-2155			Natalie E. Pyle			Havre de Grace, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										acute myocardial infarction massive							
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										DUE TO, OR AS A CONSEQUENCE OF (b) hyper tension arteriosclerosis heart disease							
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (b) (this hospital) attended the deceased from <u>May 21, 1981</u> to <u>May 29, 1981</u> , that (b) (we) lost saw the deceased alive on <u>May 21, 1981</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (I did not) (did not) view the body after death.																	
23a. SIGNATURE M. Gladden Kurtz										DEGREE M.D.							
23b. PHYSICIAN'S NAME (TYPE OR PRINT) M. Gladden Kurtz										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23c. ADDRESS 1131 Baltimore Pike, Bel Air, Md. 21014										22c. DATE SIGNED May 29, 1981							
23d. BURIAL, CREMATION, REMOVAL (SPECIFY)			23e. DATE			23f. NAME OF CEMETERY OR CREMATORIUM			23g. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			6/2/1981			St. Paul Cemetery			Pylesville, Harford, Md.								
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE M. Gladden Kurtz				
ADDRESS Jarrettsville, Md.										JUN 2 1981							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be removed carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

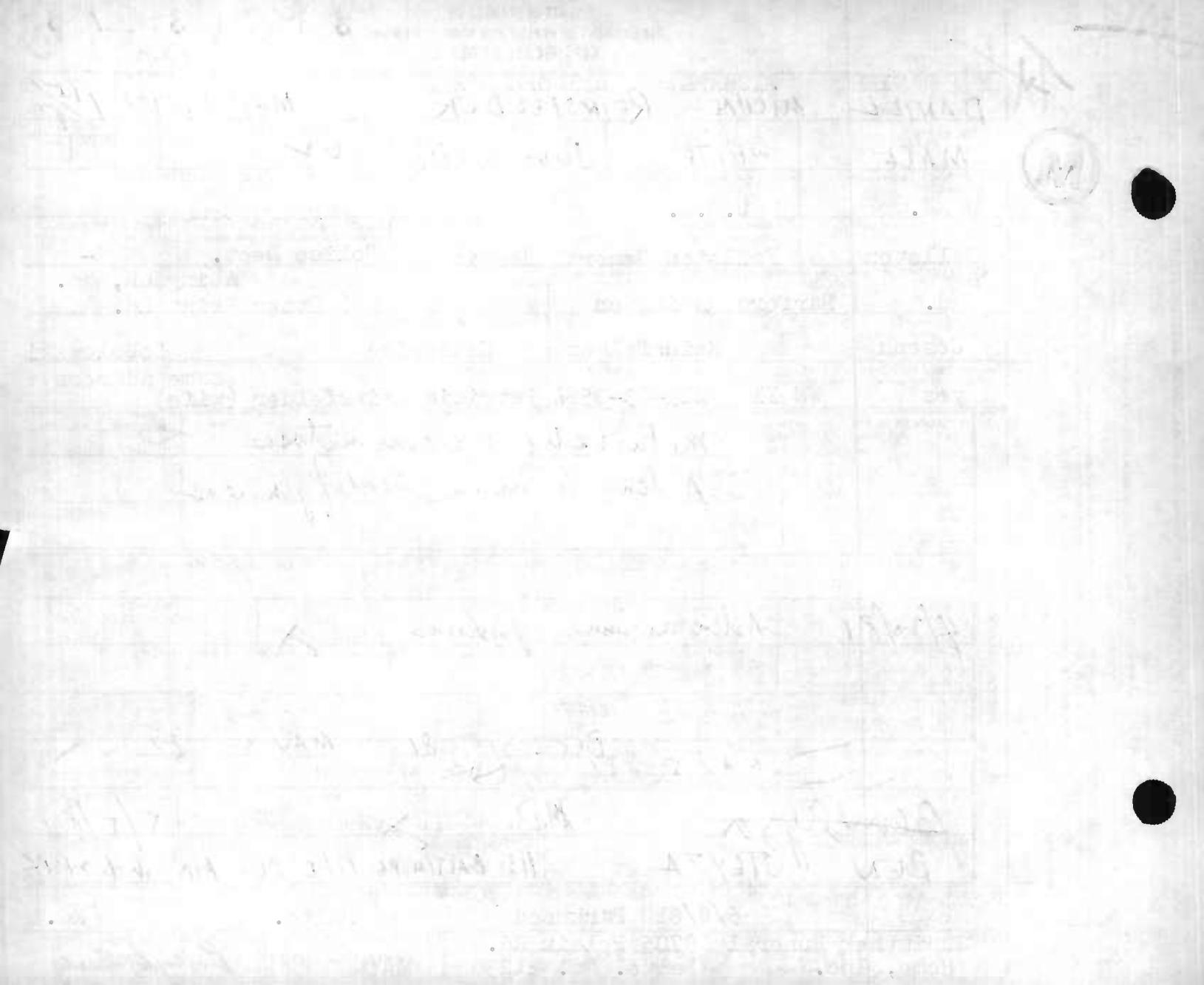
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8113478		
1. DECEASED NAME [TYPE OR PRINT] DANIEL FIRST MICHAEL REINSFELDER					2a. DATE OF DEATH MONTH DAY YEAR MAY 5, 1981					2b. HOUR 1 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 6 1918			6. AGE (IN YEARS LAST BIRTHDAY) 62		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION Police Dept.			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Harford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Abingdon, Md. 606 Otter Point Rd.					
14. FATHER'S NAME FIRST Joseph MIDDLE Reinsfelder LAST		15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE Sobolewski LAST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Patricia Reinsfelder (wife)			ADDRESS same address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1570 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma, head of pancreas												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION 4/20/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma, pancreas			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from DEC 31, 1981, to MAY 5, 1981, that (1) (we) last saw the deceased alive on MAY 5, 1981, and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (not) view the body after death.												
22b. SIGNATURE BEN STEYZA		22c. DEGREE MD			22d. ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 5/5/81	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) BEN STEYZA		22g. ADDRESS 1131 BALTIMORE Pike BEZ A.R. and 21014										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/81		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood			23d. LOCATION CITY OR TOWN Balto.		COUNTY Md.		STATE	
24. FUNERAL DIRECTOR'S NAME AND ADDRESS M. Miniek Funeral Home, Inc.		24b. ADDRESS 9705 Belair Rd. Balto. Md. 21236			24c. DATE REC'D. BY REGISTRAR MAY 8 - 1981			24d. REGISTRAR'S SIGNATURE				

BP

DHMH-16 25M
(VRA 15, 4) 1/79



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8	1	1	3	4	7	9						
					REG. NO.												
1. FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
		JOHN RICHARD REISINGER							MAY 18, 1981					7:30 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
MALE		WHITE		FEB. 12, 1920			61		MONTHS		YEARS	MONTHS		DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.								
MD.		U.S.A.					HARFORD		HARFORD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
HARFORD GRACE		650 WATER ST.			STOCK CLERK			RETIRED									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
MD.		HARFORD		HARFORD GRACE		YES <input checked="" type="checkbox"/>		650 WATER ST.									
14. FATHER'S NAME		FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE	LAST						
JOHN CLEVERLAND REISINGER						SARAH MARIE HILL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		17. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
NO		212-18-5894		Miss Rose Marie Reisinger, SAME													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b1), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myelocytic Leukemia</u>																	
DUE TO, OR AS A CONSEQUENCE OF (b) _____																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) _____																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6-7-65</u> , 19 <u>81</u> , to <u>5-11</u> , 19 <u>81</u> , that (I) (we) last saw the deceased <u>5-11-81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.																	
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						GUNTHNER, D. H. RSCH MD		131 S. Union Ave Ade G My						57881			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
BURIAL		MAY 20, 81		HARFORD MEM. GARDENS		-		MAY 20 1981						HARFORD, MD			
24. FUNERAL DIRECTOR NAME		ADDRESS															
MITCHELL FUNERAL HOME HARFORD GRACE, MD.																	

ИНО

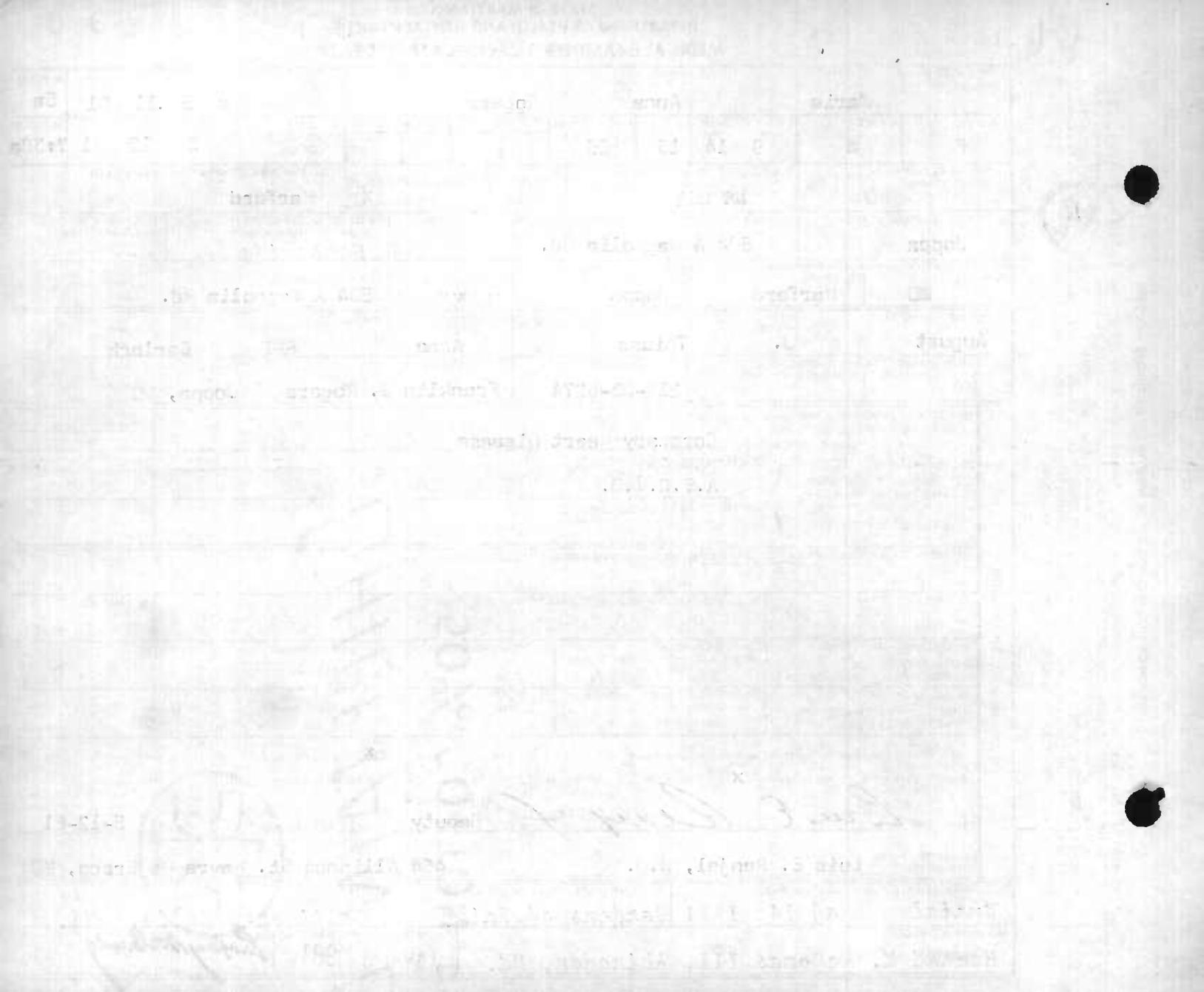
САДЫ

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 13480			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED		2b. MONTH DAY YEAR	2b. HOUR
Marie			Anna			Rogers			<input checked="" type="checkbox"/>		5 11 81	5a			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		MONTHS		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
F	W	9 14 15	65 yrs.							5 12 81	7:30a				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		NO USA			8					Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Joppa		504 A Magnolia Rd.			Housewife										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD		Harford		Joppa		XXXXX NO <input checked="" type="checkbox"/>		504 A Magnolia Rd.							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
August		J.		Thiess		Anna		NMI		Gerlock					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
NO		215-03-8274		Franklin G. Rogers, Jr		Joppa, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) <u>A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY) <u>Luis E. Renjel</u> M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 5-12-81			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 464 Alliance St. Havre De Grace, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		May 14, 1981		Gardens of Faith		Baltimore		Balto.		Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Howard K. McComas III, Abingdon, Md.				MAY 13 1981		<u>Henry McComas</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 348				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR	
(TYPE OR PRINT)			ROTEN JR.							5-6-81			3:10 P.M.	
1. DECEASED NAME FIRST MIDDLE LAST			3. SEX M			4. RACE W		5. DATE OF BIRTH MONTH / DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 58			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			MD.			
10. CITY OR TOWN OF DEATH HAURE DE GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY HARFORD			13c. CITY OR TOWN JOPPA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3319 CLAYTON Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO. 195-14-2479			17. INFORMANT ADDRESS Violet Roten P.O. Box 902 Elkton Md 21921		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO OR IS A CONSEQUENCE OF (b) Dehydration.			DUE TO OR IS A CONSEQUENCE OF (c) Generalized arterio sclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) For cerebral arteriosclerosis														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 5-1, 1981, to 5-6, 1981, that (I) (we) last saw the deceased alive on 5-5, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) did (did not) view the body after death.														
22b. SIGNATURE H. Thompson			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/6/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Thompson			22e. ADDRESS 319 So Union Ave. Anne Arundel Co.											
23a. BURIAL, CREMATION REMOVAL (SPECIFY) Burial			23b. DATE 5/9/1981			23c. NAME OF CEMETERY OR CREMATORIAL Nottingham Miss Crem. Cen.			23d. LOCATION CITY OR TOWN Nottingham Crem. Cen.			23e. COUNTY Anne Arundel Co.		
24. FUNERAL DIRECTOR NAME R. T. Ford			ADDRESS Chesapeake City Md			25a. DATE REC'D. BY REGISTRAR 5/14/1981			25b. REGISTRAR'S SIGNATURE J. M. Thompson					

15915 students are with us this year.

19. *Leucosia* *leucostoma* (Fabricius) *leucostoma* (Fabricius) *leucostoma* (Fabricius)

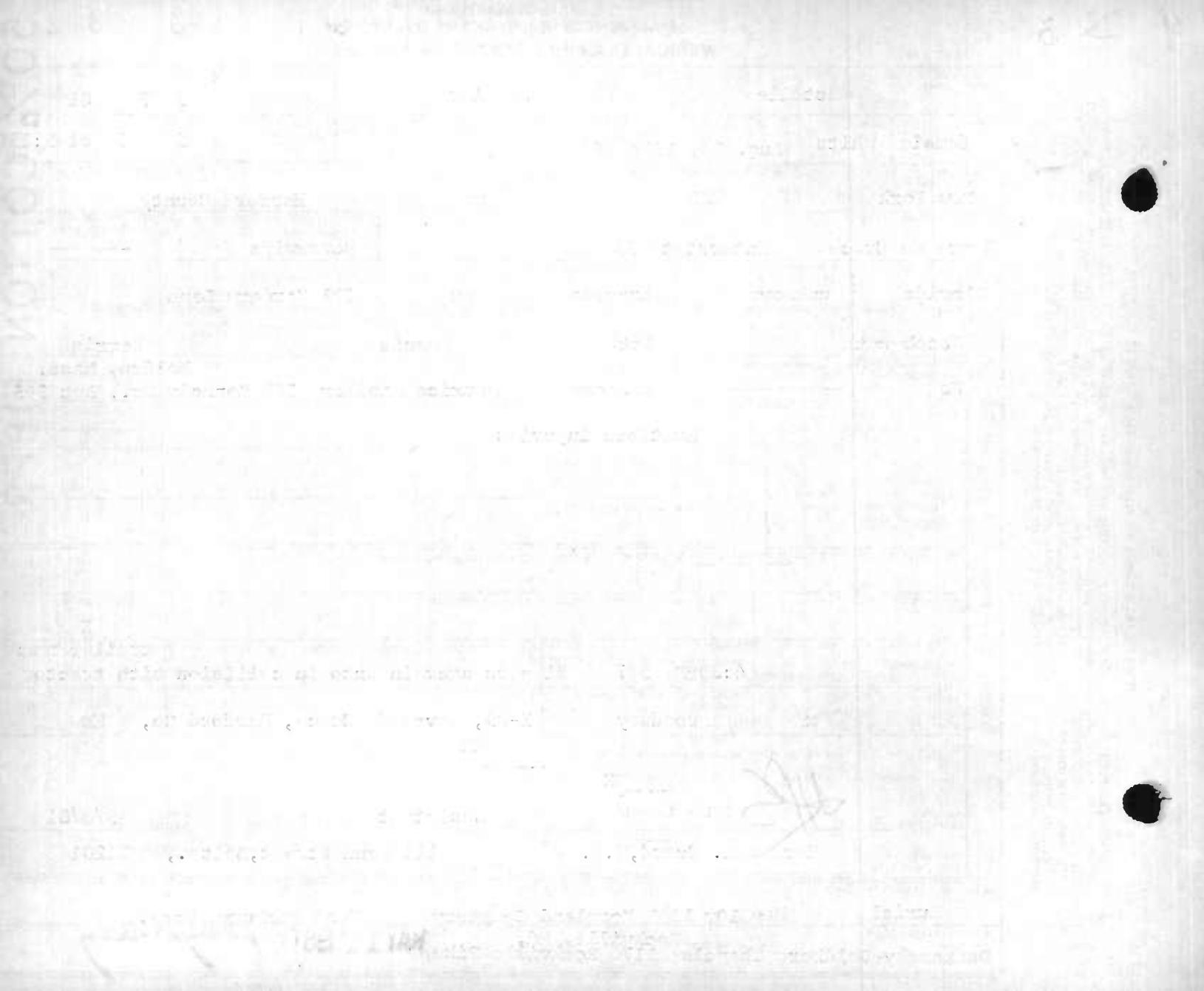
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

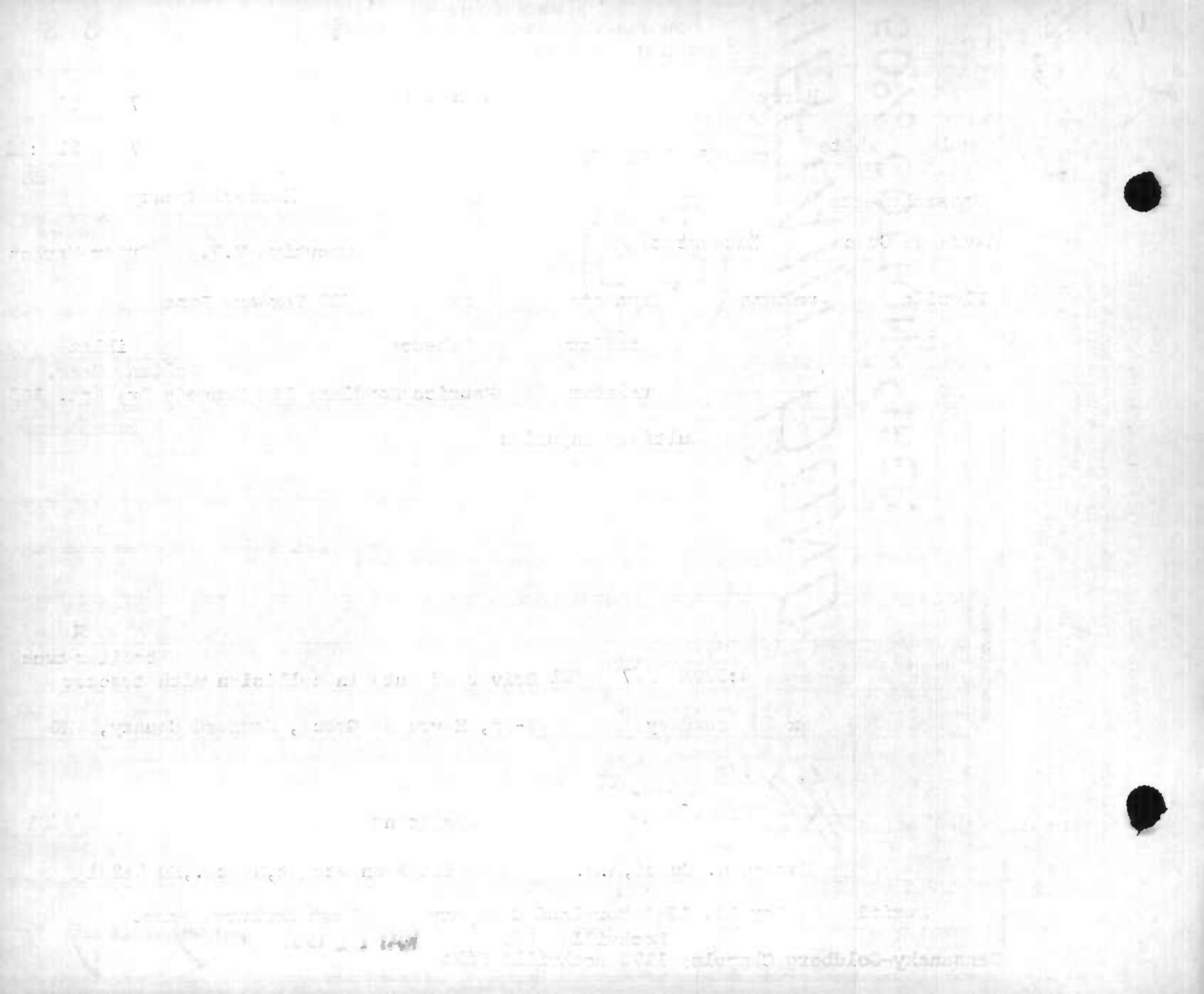
REG. NO. 13482

1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 5 DAY 7 YEAR 1981												2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST Estelle			MIDDLE			LAST Sandler			2c. DATE PRONOUNCED DEAD MONTH 5 DAY 7 YEAR 1981			2d. HOUR 5:15P					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 14, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.			IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		7. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Interstate 95												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Florida		13b. COUNTY unknown		13c. CITY OR TOWN Sarasota			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 601 Yardarm Lane										
14. FATHER'S NAME FIRST Jacob			MIDDLE			LAST Roth			15. MOTHER'S MAIDEN NAME FIRST Bessie			MIDDLE			LAST Morris					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. -----			17. INFORMANT Maurice Sandler; 192 Kennedy Dr., Apt 305			ADDRESS Malden, Mass.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which goe rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:30PM 5/7 1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in auto in collision with tractor			21f. LOCATION STREET I-95, Havre de Grace, Harford Co, MD			CITY OR TOWN COUNTY STATE								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET I-95, Havre de Grace, Harford Co, MD			CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE <i>Hormez R. Guard</i>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 5/8/81											
EXAMINER'S NAME (TYPE OR PRINT)			111 Penn Street, Balto., MD 21201 ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 10, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Moreland Cemetery			23d. LOCATION CITY OR TOWN West Roxbury, Mass.			COUNTY STATE								
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike			25. REC'D. BY REGISTRAR MAY 11 1981			26. REGISTRAR'S SIGNATURE <i>John Danzansky</i>														
BP																				
DHMH-17 (VR A15 ME (5)) 15M 2/80																				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3483		
1- STATE REGISTRAR			FIRST Harry			MIDDLE Sandler			LAST			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 5 OF ESTI- DEATH MATED <input type="checkbox"/> DAY 7 YEAR 1981	2b. HOUR M	
1. DECEASED NAME (TYPE OR PRINT)														
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 23, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 5 7 1981		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County			PM					
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Interstate 95			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive V.P.			12b. KIND OF BUSINESS OR INDUSTRY Super-Market					
13a. STATE Florida			13b. COUNTY unknown		13c. CITY OR TOWN Sarasota		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 601 Yardarm Lane					
14. FATHER'S NAME FIRST Wolf			MIDDLE		LAST Sandler		15. MOTHER'S MAIDEN NAME FIRST Rebecca			LAST Ziblat				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. -----			17. INFORMANT Maurice Sandler; 192 Kennedy Dr, Apt. 305			ADDRESS Malden, Mass.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 -----														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:30PM 5/7 1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto in collision with tractor			trailer truck					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET I-95, Havre de Grace, Harford County, MD			CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Hormez R. Guard</i>												Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		
23a. EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		
23b. DATE Burial			23c. NAME OF CEMETERY OR CREMATORIAL Moreland Cemetery			23d. LOCATION CITY OR TOWN West Roxbury, Mass.			COUNTY STATE					
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels			ADDRESS 1170 Rockville Pike			25a. REC'D. BY REGISTRAR MAY 11 1981			25b. REGISTERED SIGNATURE <i>Hormez R. Guard</i>					
BP			DHMH-17 (VR A15 ME (5))			15M 2/80								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 8 4									
1 - STATE REGISTRAR			REG. NO.																		
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
		WILLIAM		JOHN		SARGENT		May 28, 1981						5:30 M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 14 HRS									
MALE		WHITE		MONTH 04 DAY 23 YEAR 1894		87 YRS.			MONTHS			DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
PENNSYLVANIA		U.S.A.					HARFORD COUNTY			FALLSTON			FALLSTON GENERAL HOSPITAL			TAX CONSULTANT			MD.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			124 CHESTNUT AVENUE			19072					
PENNSYLVANIA				NARBERTH																	
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
		AARON				SARGENT		LILLIAN			159-05-4654			GEORGE LAMB			MALVERN, PENNSYLVANIA 19355				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				
YES		WW I					4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		4100 a cardiac myocardial infarction		4100 DUE TO, OR AS A CONSEQUENCE OF a cardiac myocardial infarction		4100 DUE TO, OR AS A CONSEQUENCE OF a cardiac myocardial infarction		4100 DUE TO, OR AS A CONSEQUENCE OF a cardiac myocardial infarction		4100 DUE TO, OR AS A CONSEQUENCE OF a cardiac myocardial infarction				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?			20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY?			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			20e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			21g. CITY OR TOWN		21h. COUNTY		21i. STATE			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			21g. CITY OR TOWN		21h. COUNTY			21i. STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>May 18, 1981</u> to <u>May 18, 1981</u> , that (I) (we) last saw the deceased alive on <u>May 18, 1981</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>BEN OYEZA</u>		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN X DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 1131 Baltimore Pike Rd AIR Md 21014			22f. DATE SIGNED 5/28/81									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 06-01-81		23c. NAME OF CEMETERY OR CREMATORIAL GOOD SAMARITAN			23d. LOCATION CITY OR TOWN WILLISTOWN		23e. COUNTY CHESTER			23f. STATE PA.									
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		24b. ADDRESS BALTIMORE, MD. 21229		24c. DATE REC'D. BY REGISTRAR JUN 1 1981			24d. REGISTRAR'S SIGNATURE <u>Registrator</u>														
BP _____		DHHM - 16 50M 1/76 (VR A 15 (4))																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Opt. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										81	13485													
										REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR							
CHARLES THOMAS Soul			S R.									5-25-81					3:09							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7a. DATE OF DEATH		7b. MONTH		7c. DAY		7d. YEAR		7e. HOUR				
m			Cauc.			MONTH 4 DAY 9 YEAR 86			65			5-25-81		IF UNDER 1 YEAR		IF UNDER 24 HRS		3:09						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH															
Maryland			USA						Harford County															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY															
Fallston			Fallston General Hospital			Chem. Opr.			Chemical															
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS												
Maryland			Harford			Abingdon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1117 Bush Road												
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			16. ADDRESS												
Joseph			--			Soul			Marie			Koci												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
NO			705-12-5153			Mrs. Alice Soul, Abingdon, Md.																		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Cardiopulmonary arrest																					
4275																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (b)																		
						DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE									
22a. I certify that (I) (this hospital) attended the deceased from May 25, 1981, to May 26, 1981, that (I) (we) last saw the deceased alive on May 25, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED															
Joseph Reinhard																								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ADDRESS																					
Joseph Reinhard																								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE									
Burial			May 28, 1981			Harford Mem. Gardens			Aldine			Harford			Md.									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE ENCLOSED BY REGISTRAR			25b. REGISTRATION NUMBER															
Howard K. McComas III, Abingdon, Md.						May 27, 1981																		

1000-1000

1000-1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES LAND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF EST- DEATH MATED				MONTH DAY YEAR			2b. HOUR			
Emmett Chase Spicer								<input checked="" type="checkbox"/> 5 - 30 1981				5 - 30 1981			p.m.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.					2c. DATE PRONOUNCED DEAD	
M		W		12 - 14 - 06			74 yrs.			MONTHS		DAYS					MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA											Harford County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Joppa		2007 Mountain Road										Supr. Mtn.				Co. Hwy.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Maryland		Harford		Joppa						2007 Mountain Road								
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME													
George		Brown			Spicer			Louise			M. Turner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
NO		222-05-0065																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic & Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF 4029 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) <u>cardiovascular disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Samuel H. Henck</u> M.D. Deputy MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) <u>Samuel H. Henck</u> ADDRESS <u>721 Wheeler School Rd., White Ford, Md. 21160</u>															TITLE (SPECIFY)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Cemetery Christian			23d. LOCATION CITY OR TOWN			23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE					
Burial		June 3, 1981						Joppa			Harford		Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS																
Howard K. McComas III, Abingdon, Md.											JUN 5 1981		Lister, Henck					
DHMH - 17 (VR A15 ME (5)) 15M 2/80																		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13487

1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH	DAY	YEAR	2b. HOUR	
Lawrence Gilbert							Spurrier		<input checked="" type="checkbox"/>		5-4	19	81	7:51 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
M	W	June 7, 1925	55 yrs.	MONTHS	DAYS	HOURS	MIN.	5-4	19	81	7:51 p.m.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA										Harford County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Fallston		Fallston General Hospital		Criminal Invest.		U.S. Army Ret									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Harford		Edgewood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2424 Hanson Road							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Gilbert		--		Spurrier		Elsie		--		Bowen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR & STATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
Yes WWII, Korea		Vlet. 216-20-0040		David L. Spurrier, Oakland, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Probable coronary artery occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4100		DUE TO, OR AS A CONSEQUENCE OF				Minutes									
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		{ (b) A.S.C.V.D.				Years									
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion											
ACTUAL SIGNATURE		M.D. Deputy		TITLE (SPECIFY)											
EXAMINER'S NAME (TYPE OR PRINT)		Samuel H. Henck		721 Wheeler School Rd., White Ford, Maryland 21160											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
Burial		May 8, 1981		Arlington Nat. Cem.		Arlington		Arlington		Va.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Howard K. McComas III, Abingdon, Md.				MAY 6 - 1981		Loyd Schenck									

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1

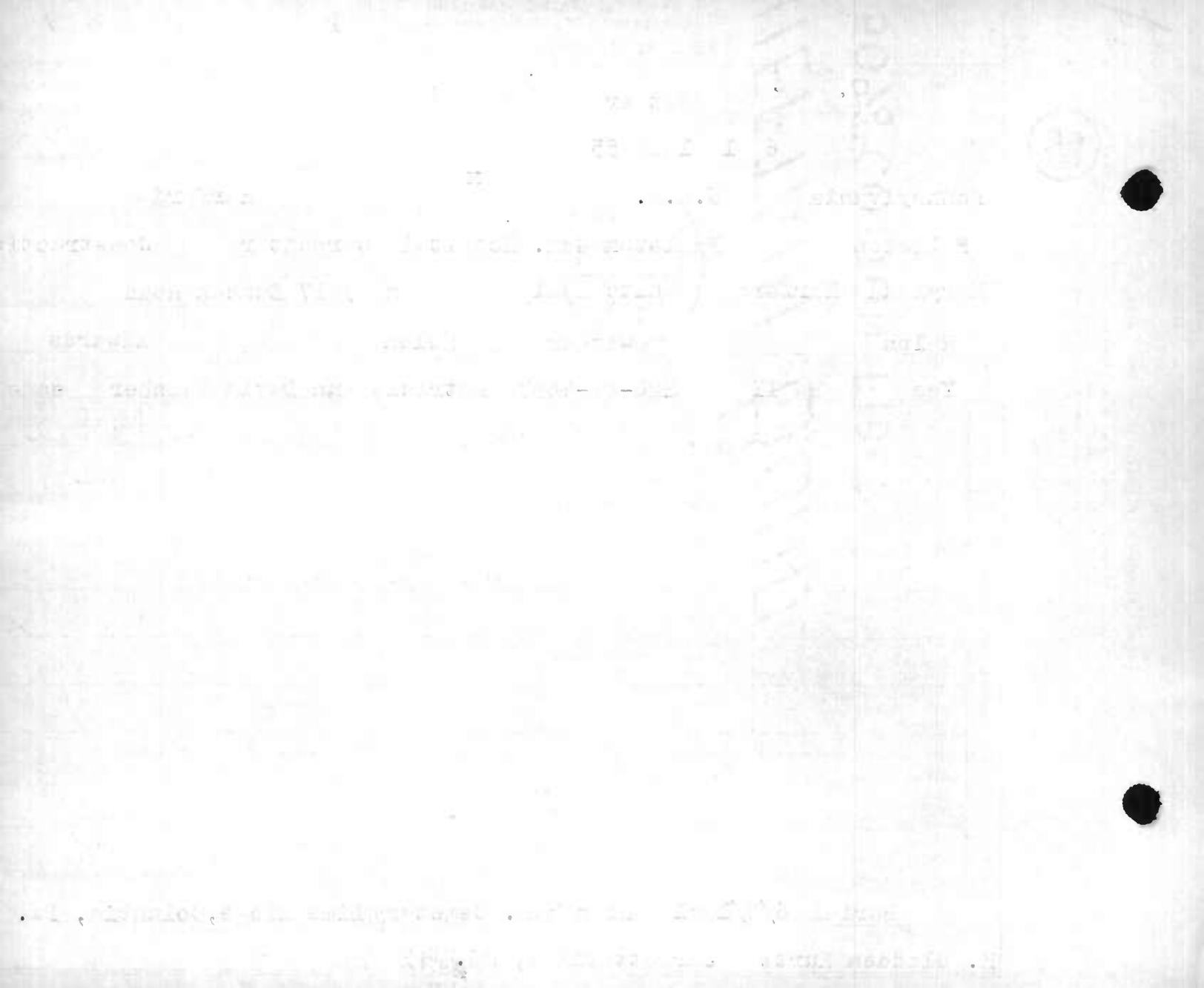
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	8	8	
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
WILLIAM PAULINE STAHLER												5 22 81		4	22	81	46		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS							
F		Caucas		MONTH 10 DAY 17 YEAR 20			60			MONTHS		DAYS		HOURS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.									
Virginia		USA					HARFORD												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
FALLSTON		FALLSTON GENERAL Hosp										Housewife		--					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
												Md.		HARFORD Aberdeen		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2007 Tower Road	
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST							
John		--		Richardson			Annie			--		Larince							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)										17. INFORMANT		ADDRESS					
no		212-30-2407										Mrs. Nancy Lohr, Edgewood, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												1/2 hr?							
4549 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.												Cardioresp. arrest							
DO TO, OR AS A CONSEQUENCE OF (b) Prefable Acute MI or Pulmonary Embolism												1/2 hr?							
DO TO, OR AS A CONSEQUENCE OF (c) Varicose Vein (D) thigh painful (yrs)												Family refused autopsy							
PART 2. OTHER/SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (1) this hospital attended the deceased from May 15, 1981, to May 21, 1981, that (1) we lost saw the deceased alive on 9 pm May 21, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.																			
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED									
Albert S.C. Sun, M.D.										5/21/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			1800 Harford Rd. Fallston 21047											
Albert S.C. Sun, M.D.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		May 26, 1981			BelAir Mem. Gardens			BelAir		Harford		Md.							
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Howard K. McComas III, Abingdon, Md.								MAY 26 1981		Lester McComas									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 13489			
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 5 DAY 28 YEAR 1981									2b. HOUR 3:51 P.M.			
1. DECEASED NAME (TYPE OR PRINT) Bryce Butler Swisher			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD 5 28 1981			2d. HOUR 3:51 P.M.			
3. SEX Male		4. RACE Wh		5. DATE OF BIRTH MONTH 6 DAY 1 YEAR 1925		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.					
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford									
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen. Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN White Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3017 Duncan Road				12b. KIND OF BUSINESS OR INDUSTRY Construction			
14. FATHER'S NAME FIRST Ralph		MIDDLE		LAST Swisher		15. MOTHER'S MAIDEN NAME FIRST Helen		MIDDLE				LAST Edwards			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT 226-22-4697		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable myocardial infarction Minutes 4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) A.S.C.V.D. Years (c)		ADDRESS Patricia Ann Davis Swisher same							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Hypertension Chronic lung disease.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Samuel H. Henck		M.D.		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 5/28/81							
EXAMINER'S NAME (TYPE OR PRINT) Samuel H. Henck		ADDRESS 721 Wheeler School Rd. White Ford, Md. 21160													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/2/1981		23c. NAME OF CEMETERY OR CREMATORIAL Elan Mem. Cemetery		23d. LOCATION CITY OR TOWN Lime Ridge, Columbia, Pa.		23e. COUNTY		STATE					
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz		ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR JUN 2 1981		25b. REGISTRAR'S SIGNATURE									
DHHM-17 (VRA15 ME (5))															
15M 2/80															

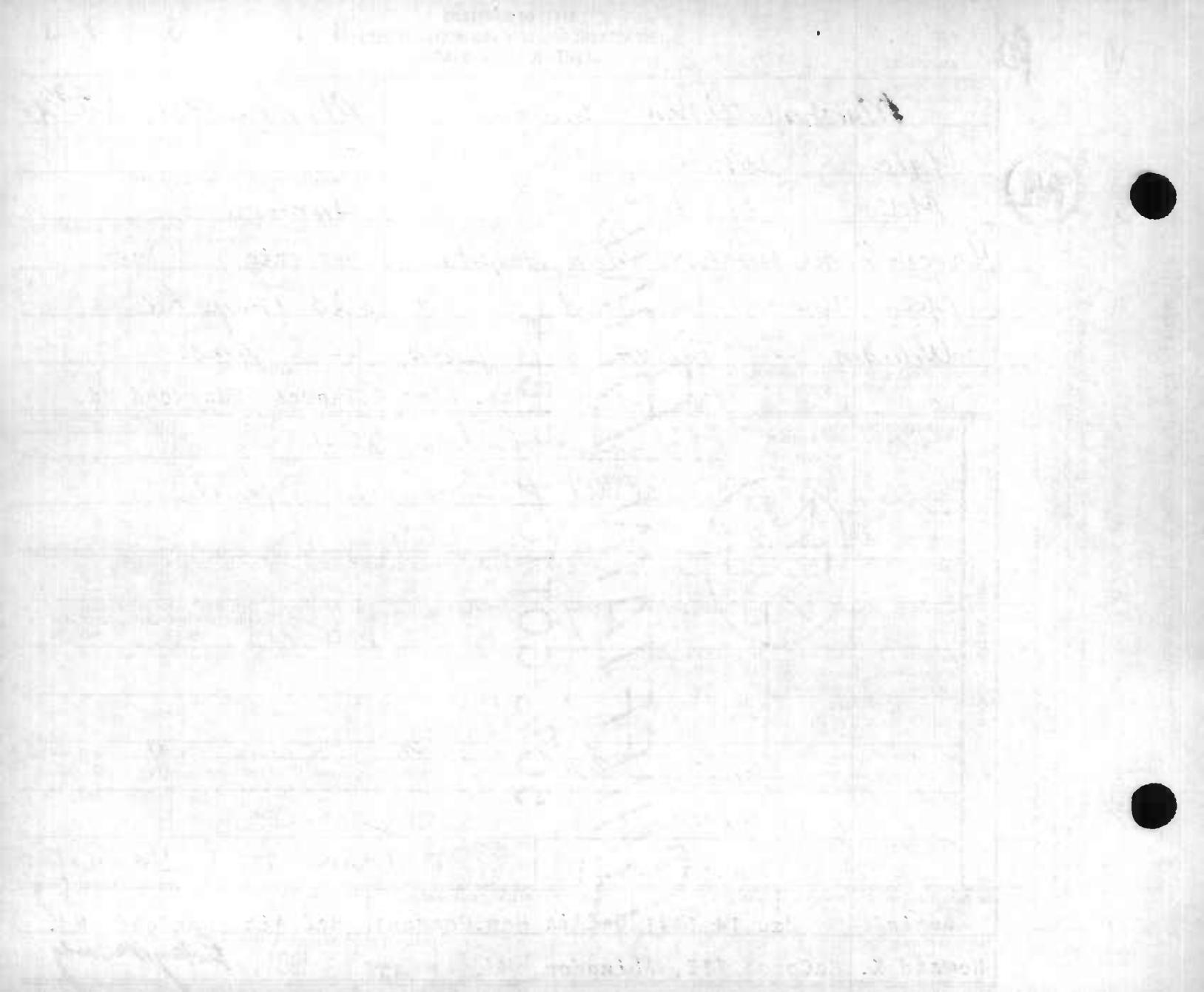


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon/papers. Pages 1 and 2 should be filed with the funeral director.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8113490			
												REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			1. FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 2:30 24 M			
Marshall Wilton Thomas									May 12, 1981						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Aug. 16, 1908 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE COUNTRY Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.								
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SURFACE FACILITY, GIVE STREET ADDRESS) Grace Harford Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto								
13a. STATE Md		13b. COUNTY Harford		13c. CITY, OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 525 Freys Rd.					
14. FATHER'S NAME William		15. MOTHER'S MAIDEN NAME Lida													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-01-6425		17. INFORMANT Mrs. Alma C. Thomas, Edgewood, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Dystrophy															
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Dis.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 5/11, 1981, to 5/12, 1981, that (I) (we) last saw the deceased alive on 5/13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE Howard K. McComas III		22c. DEGREE BelAir Mem. Gardens			22d. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED May 13, 1981							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard K. McComas III		22e. ADDRESS 611 S. Union Ave, Harford, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 14, 1981		23c. NAME OF CEMETERY OR CREMATORY BelAir Mem. Gardens			23d. LOCATION CITY OR TOWN Bel Air Harford, Md.								
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.		25a. DATE REC'D. BY REGISTRAR MAY 13 1981			25b. NECESSARY SIGNATURE Loring McComas										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 16 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	1	3	4	9	1		
												REG. NO.								
1. FOR STATE REGISTRAR			James Franklin Vuncannon																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Male			White			3 15 1916						May 4 1981			12	45	26	12 45 PM		
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			MONTH DAY YEAR						65			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD					
Mississippi			USA									Harford								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Harve de Grace			Harford Mem. Hospital									Army			Military					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Md			Harford			Aberdeen			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			625 Rogers St								
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME								
												UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						ADDRESS			21001					
Yes			WW-II			009-42-1567						Erna Vuncannon, 625 Rogers ST., Aberdeen, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:												APPROPRIATE NARRATIVE BETWEEN DEATH AND HEALTH								
IMMEDIATE CAUSE (a) <i>Acute Inferior Wall Myo -</i> 4100 DUE TO, OR AS A CONSEQUENCE OF <i>Cardiac Infarction</i> <i>Sudden</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>with Ventricular fibrillation</i>																				
(b) <i>Coronary Artery Disease Several</i> DUE TO, OR AS A CONSEQUENCE OF <i>years</i> (c)																				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE WHICH EXAMINED)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)														
			P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>5-3</i> , 19 <i>81</i> , to <i>5-4</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>5-4</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>Edward C. Loo, M.D.</i>			DEGREE <i>M.D.</i>									ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5/4/81</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EDWARD C. Loo, M.D.</i>			22e. ADDRESS <i>Harve de Grace, Md. 21078</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5 May 1981			23c. NAME OF CEMETERY OR CREMATORIAL Harford Mem. Gardens			23d. LOCATION CITY OR TOWN Aberdeen, Md.			23e. COUNTY Harford			STATE Md.					
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001												24e. DATE REC'D. 1981 <i>MAY 6 1981</i>								

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Digitized by srujanika@gmail.com

188. *Wolffia* *trilobata* *Linn.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 . 1 3 . 4 9 2				
1 - STATE REGISTRAR			REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
TIMOTHY							WARREN			5 / 28 / 81				11-10 M		
3. SEX MALE		4. RACE B			5. DATE OF BIRTH 01 06 28		6. AGE (IN YEARS LAST BIRTHDAY) 53			7. IF UNDER 1 YEAR YRS.		8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.			7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.									
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad foreman			12b. KIND OF BUSINESS OR INDUSTRY AMTRAK								
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		14. FATHER'S NAME FIRST Robert Warren		15. MOTHER'S MAIDEN NAME FIRST Essie Arnold		16. ADDRESS 822 NORTH APAMS STREET				
16a. DIED YES IN U.S. OR UNKNOWN		16b. SOCIAL SECURITY NO. ARMY 50-56 XXXX-XX-XXXX		17. INFORMANT ESSIE WARREN 719 EDMUND ST. ABERDEEN		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4329		19. DUE TO, OR AS A CONSEQUENCE OF (b) INTRACRANIAL HEMORRHAGE		20. DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5 / 28 / 81, 19 81, to 5 / 28 / 81, 19 81, that (I) (we) last saw the deceased alive on 5 / 28 / 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) view the body after death.																
22b. SIGNATURE M. A. Thomas M.D.		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 5 / 28 / 81										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. A. THOMAS		22e. ADDRESS FALLSTON GEN. HOSPITAL 200 MILTON AVE., FALLSTON MD 21047														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial Transit		23b. DATE 31 May 81		23c. NAME OF CEMETERY OR CREMATORIAL Mt Moriah Baptist Cem		23d. LOCATION CITY OR TOWN Greenwood		COUNTY		STATE Greenwood S.C.						
24. FUNERAL DIRECTOR NAME T.M. Tanning Funeral Home, P.A.		ADDRESS Maryland 21001		25a. DATE REC'D. BY REGISTRAR JUN 9 1981		25b. REGISTRAR'S SIGNATURE S. J. Brady										

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3. - C.

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100% brachytherapy of recurrent disease and

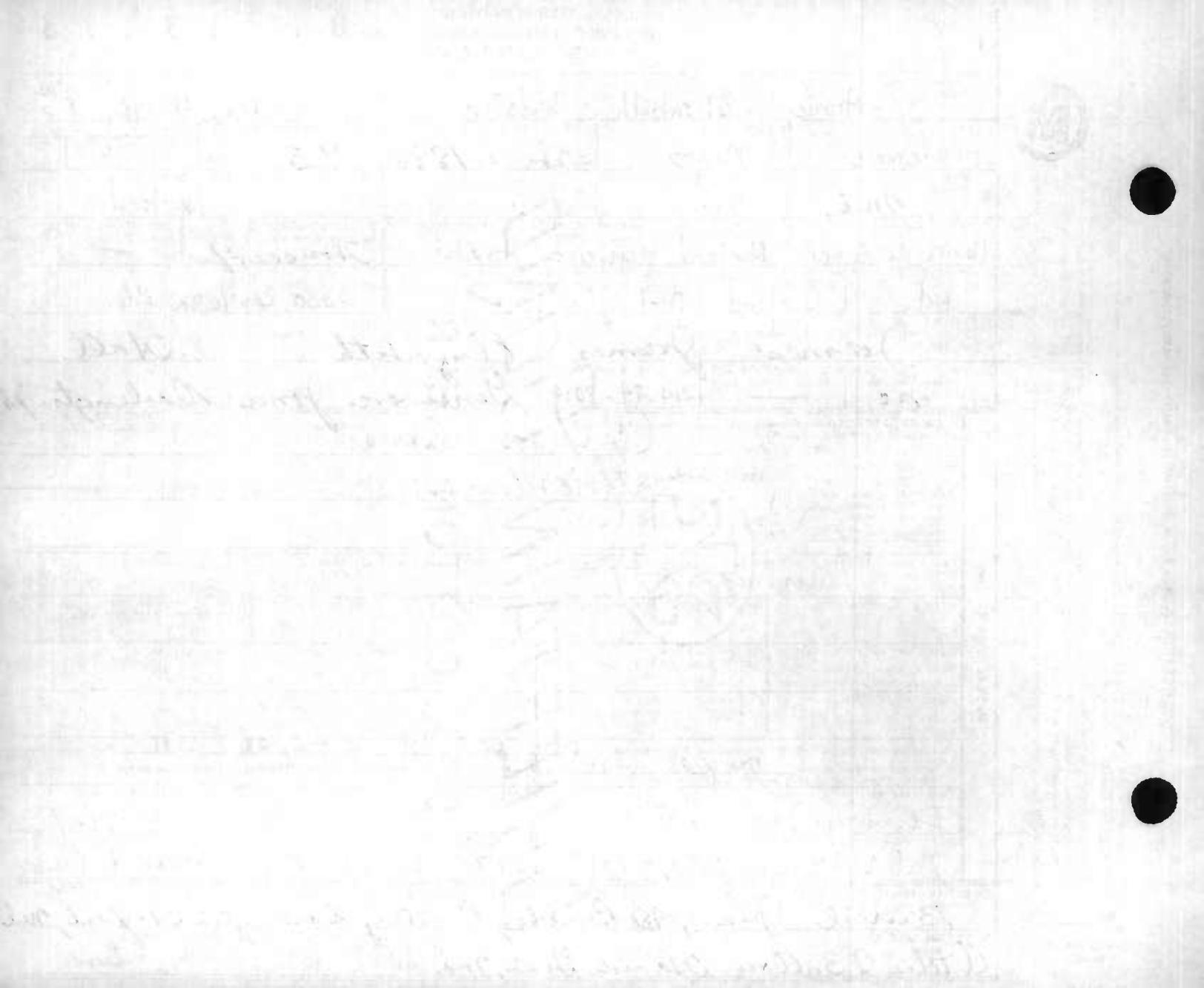
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8113493					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Annie Elizabeth Webster						May 28 1981						10 8 P M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 1 HRS	
Female			Negro			Month Day Year Feb. 1, 1888			93			MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.			USA									Harford			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Harve de Grace			Harford Memorial Hospital			Housewife									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Md.			Harford			Darlington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2330 Castleton Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME Elizabeth Hall												
James			James												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Genevieve Jones Darlington			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no			214-74-8019												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>															
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>May 15 1981</u> to <u>May 28 1981</u> , that (I) (we) last saw the deceased alive on <u>May 28 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Dante Monakil, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/29/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MONAKIL, DANTE			22e. ADDRESS 622 S. UNION AVE HARVE DE GRACE												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 1, 1981			23c. NAME OF CEMETERY OR CREMATORIUM Berkeley Cemetery			23d. LOCATION CITY OR TOWN Darlington			STATE Md.			
24. FUNERAL DIRECTOR NAME Oteilie J. Bullock, Hanover Grace, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 1 1981			REGISTRAR'S SIGNATURE Lily McCreedy						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					81	13494		
					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)	FIRST LESTER		MIDDLE H.	LAST WILSON	2a. DATE OF DEATH MONTH MAY	DAY 7	YEAR 1981	2b. HOUR 8:23PM
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH 5 DAY 15 YEAR 99		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 81 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PA</i>	8. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH <i>HAVRE DE GRACE</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>CITIZENS NURSING HOME</i>				12a. USUAL OCCUPATION <i>PTT TOLL CO., ADULT</i>			
13a. STATE <i>MD</i>	13b. COUNTY <i>CECIL</i>	13c. CITY OR TOWN <i>RISING SUN</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS —			
14. FATHER'S NAME FIRST <i>SCOTT</i>	MIDDLE <i>C</i>	LAST <i>WILSON</i>	15. MOTHER'S MAIDEN NAME FIRST <i>MARY</i>		LAST <i>COONEY</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	16b. SOCIAL SECURITY NO <i>216-07-5771</i>	16c. INFORMANT <i>MARY SMITH</i>	17. ADDRESS <i>W. PLAIN BEACH FLA</i>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —			
18. CAUSE OF DEATH (Enter only one cause per line for Part 1a and 1b) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4292</i>					DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
					DUE TO, OR AS A CONSEQUENCE OF (c) —			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>old fracture of left hip.</i>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) —			21d. LOCATION STREET CITY OR TOWN COUNTY STATE			
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>3125</i>							
22a. I certify that, (1) (this hospital) attended the deceased from <i>5/8/81</i> to <i>5/8/81</i> , that (1) (we) last saw the deceased alive on <i>5/8/81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.								
22b. SIGNATURE <i>John D. Yau</i>	22c. DEGREE —			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>5/8/81</i>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John D. Yau</i>	22f. ADDRESS <i>Havre de Grace, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>5-11-81</i>	23c. NAME OF CEMETERY OR CREMATORIAL LEVEL <i>CHESTNUT LEVEL</i>		23d. LOCATION CITY OR TOWN <i>Lancaster Co., PA</i>	23e. COUNTY <i>Lancaster Co.</i>	STATE <i>PA</i>		
24. FUNERAL DIRECTOR NAME <i>R.F. Forst Funeral Home</i>	ADDRESS <i>Rising Sun, MD 21642</i>		25e. DATE REC'D. BY REGISTRAR <i>MAY 13 1981</i>		25d. REGISTRAR'S SIGNATURE <i>John D. Yau</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked "X" on item 18 shows any injury, or other traumatic event, the medical examiner must be notified or contact the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 3 4 9 5
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
William LEE Wilson						5/8/81				7:50 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			7. IF UNDER 24 HRS		
MALE	Caucasian	MAY 29, 1989 91			91	MONTHS	YEARS	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
MD	Harford				Harford			FALSTON			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Fellston General Hospital		SCHOOL CATERER		RETIRED							
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD		Harford		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		303 Lakeside Drive					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S M AIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 2765		16b. SOCIAL SECURITY NO.		17. INFORMANT			
HENRY		Priscilla Gover LEE		(YES, NO OR UNKNOWN) 2765		218-14-7268		Mrs. JEANNE RICKETS ABINGTON, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
2765 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
2765		21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			
22a. I certify that (I) (has/had) attended the deceased from 5/19/81 to 5/8/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on 5/7/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE B. Nowakowski, MD		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 5/8/81					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS 715 Shamrock Rd, Bel Air, MD 21010		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE May 11, 1981		23c. NAME OF CEMETERY OR CREMATORIAL TRINITY CHURCH YARD		23d. LOCATION CITY OR TOWN CHURCHVILLE, HARFORD, MD COUNTY STATE	
23e. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME, HARFORD GRACE		23f. ADDRESS 1101		25a. DATE REC'D. BY REGISTRAR MAY 13, 1981		25b. REGISTRAR'S SIGNATURE Lee					

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